The American
Journal of Nursing

Volume 38 *Number 1*

January 1938

Nursing in China

By EVELYN LIN

This is the story of the development of nursing in China written by the president of the Nurses Association of China.

NURSING AND MEDICINE have a close relationship with each other because both are working for the purpose of serving humanity. I would like to say a few words about the history of medical work in China before I discuss the development of nursing.

MEDICINE IN ANCIENT CHINA

The art of medicine was mentioned in Chinese history as far back as between 2900-2800 B.C. when Shen Lung wrote *Pen Tso*, which is considered the oldest Chinese medical book. This was not recognized by the public until 206 B.C., but the writer is now worshipped by the native drug dealers as the "Father of Medicine."

The Yellow Emperor and Ch'i Pai of 2700-2600 B.C. wrote the *Canon of Medicine* which includes various subjects, such as pathology, anatomy, theory of pulse, technic of puncture, and conservation of health. This is still regarded as a very important medical book by the native doctors although it was written 3,000 years ago. From some of the historical findings, this book might have been written by various writers during the Chou or Ching Dynasty 722–210 B.C.

Yu Fu was a famous surgeon in the earliest period of Chinese surgical history. He performed minor operations on the skin, dissected muscles, tied blood vessels and did gastric and duodenal lavage.

Chinese medicine did not become a science until the Han Dynasty, 180 B.C.–190 A.D. The outstanding men of Chinese medical history are Chang Chung-ching, Chang Kung, and Hwa T'O. Chang Kung wrote a book on clinical records. Chang Chung-ching was known as the Chinese Hippocrates and Hwa T'O was a famous surgeon who discovered anesthetics. There was also, during this period, a woman obstetrician by the name of C'hun Yu-yen, who had the distinction of being called to treat the Empress. Her remedy was a pill of aconite.

In 608 A.D., China was so far advanced in medicine that the Japanese govern-

ment sent several young men to China to study. This high position in the medical field was held by China until the middle of the nineteenth century when Western medicine was brought into Eastern Asia.

In 1835, Dr. Peter Parker opened a hospital in Canton. This was the nucleus of modern medicine in China. His influence was very far reaching and as a result many hospitals were opened in different parts of China.

Early Nursing History

There is no record in Chinese history before the nineteenth century by which we can trace the words "nurse" or "nursing." One may wonder why nursing was neglected by our ancestors. Did we Chinese people take care of our sick in the olden times? Did the status of women affect the work of nursing? How did the doctors manage hospitals during the forty-nine years before modern nursing came to China?

The following suggestions may help us to understand. First, there is no record of nursing in the early history of China. This is not surprising as the same experience has been true in many other countries. Our ancestors probably did not realize that those who helped with the care of the sick played a great part in the curing of disease. This traditional prejudice is still fixed in the minds of some of our doctor friends in China today.

The care of the sick in olden times was done by relatives and servants. When the Emperor was sick his prime minister would wait on him, as well as members of the royal family. All food and medicine were tasted by the prime minister before they were given to the emperor. The same was done by the daughters and sons in the case of illness of either parent. Servants helped in many other ways.

Chinese women who could afford it were educated by private tutors; others by their parents. They were taught to

Classroom Practice at the School of Nursing, Peiping Union Medical College

TEACHING HEALTH TO THE FAMILY
Left to right: the nurse, the patient, the grandmother. Note the portable stove.

study Confucius' *Classics*, to write some poems, to be obedient to their parents, to respect their husbands (this did not mean that women were not on the same plane as men, or controlled by them, as might be interpreted), to care for children, and to do other domestic work. They did not have many social activities except some gatherings among their own sex, such as birthday parties and other special occasions. Young women were not allowed to go out without a chaperon. It was not the custom for women in society to work. It is obvious that women of that period did not attempt to take care of the sick outside their own family circle. Other ways of doing charitable work were to give money for certain amounts of rice and clothing for the poor in the winter and to provide tea for coolies along the streets in the summer.

The nursing care of the middle of the nineteenth century was done entirely by a servant type of nurse, who was taught to do some manual work. Medicine and treatment were handled by the doctors. Some of these nurses were unable to write and read very little. I was told by one of the older nurses that it was necessary to mark the bottles so that all nurses would understand, e.g., an eye would be drawn on the zinc sulphate solution, indicating eye medicine, and a hand on the lysol solution bottle, indicating its use for washing hands.

THE NIGHTINGALE SYSTEM

Modern nursing in China completed her fifty-fourth birthday this year. She is still very young compared with nursing in other nations. Elizabeth McKechnie of the United States brought the Florence Nightingale system of nursing to China for the first time on a rainy day, March 24, 1884, when she planted the seed at the West Gate Red House Hospital, now known as Margaret Williamson Hospital, Shanghai. Miss Mc-

A Student's Room, School of Nursing, Peiping Union Medical College

Kechnie and her friend Dr. Elizabeth Reifsnyder had a very difficult time on account of lack of equipment and trained personnel.

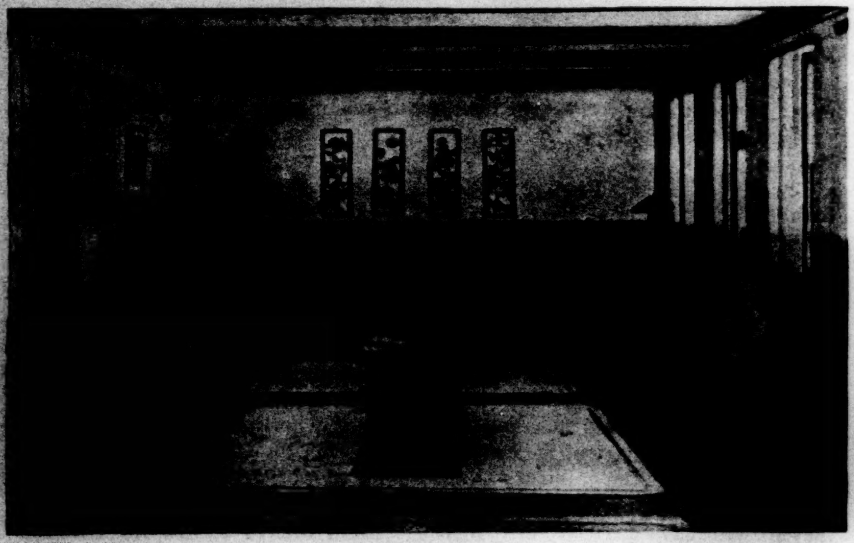
Since then many foreign nurses have come to China to help with nursing education, among whom are Ella Johnson, Alice Powell, Nina Gage, Cora E. Simpson, Mary Hood, Gladys Stevenson, Anna D. Wolf, and others. It was through their vision, effort, and the hardships endured that nursing in China has developed to the present status.

Modern nursing in China could be divided into three periods: the first from 1884 to 1904; the second, from 1904 to 1924; the third from 1924 to the present date.

The first period 1884–1904.—Ella Johnson established the first training school for nurses in connection with Liang Au Hospital, Foochow, Fukien, in 1888 with two nurses in the first class. Practical nursing, midwifery, and dispensing were taught at the convenience of the teachers and when the work of the ward permitted. The first graduation was held in 1890. This gives us an idea that the length of the course was two years. Soon many other hospitals opened training schools for nurses with the idea of obtaining better nursing service for the hospital.

These schools did not emphasize the educational background of the student, for nursing was too new for people to appreciate and understand what was really meant by nursing. Since educated women were not willing to take up this kind of task and hospitals needed personnel, the door was opened for the servant type of nurse to step into our respectable profession. The motive of most, if not all, students at that time on entering was to receive the allowance given by the school. In the early days the Wu Han Branch of the Medical Association gave simple examinations to four or five schools in the Wu Han District.

The second period 1904–1924.—Many important events happened during this period. First of all was the organization of the Red Cross Society, during the



LIVING-ROOM IN THE NURSES' DORMITORY, SCHOOL OF NURSING, PEIPING UNION MEDICAL COLLEGE

Russo-Japanese war in 1904, by Chinese residents in Shanghai who collected the sum of $500,000 for relief in Southern Manchuria. A Red Cross hospital was opened in 1907 and financed by the fund left from that collected for the relief work. The Red Cross has rendered a great service in many ways, in famine, flood, and civil war relief. There are now 500 or more branch societies of the Red Cross in the different parts of China.

A school of nursing was established in connection with the Chinese Red Cross Hospital in Shanghai in 1921. Lillian Wu was the first principal of this school and her successor was Mrs. Chi-ying Lu Li, who has done a wonderful piece of work.

The Nurses Association of China, known as the NAC, was founded in 1909 and reorganized in 1912. A brief outline of the standard curriculum and regulations regarding national examinations were planned, but the first examination for nurses was not given by the Nurses Association of China until 1915, when seven candidates were examined.

The first issue of the *Nursing Journal of China* (which is issued quarterly) was published in 1920 and it has been self supporting from the beginning. The Nurses Association of China joined the International Council of Nurses in 1922 and has been able to send delegates to each quadrennial meeting. The income of the Association depends largely on the membership fees and partly on student assessment. The functions of the Association are as follows:—

1. To register both schools of nursing and graduate nurses.
2. To plan and give national examinations to nurses.
3. To serve as an employment bureau for both graduate nurses and hospitals.
4. To compile, translate, and revise books for schools of nursing in China.

We extend our gratitude to Cora E. Simpson for her hard work, loyalty, and faithfulness to the Association. She is really its founder and staunch supporter.

Many prominent schools were established during this period, among them were the schools of nursing of Hunan-

Yale Hospital, Changsha, Hunan; of Margaret Williamson Hospital, Shanghai; of Sleeper Davis Hospital, Peiping; and that of the Peiping Union Medical College, known as PUMC, Peiping.

The requirements for the prenursing background were varied, some required entering students to have lower primary, some junior middle school, and others senior middle school education. The school of nursing of Peiping Union Medical College required senior middle school graduation, but preferred college education. It offered a combined university and nursing course in affiliation with Yenching University, which is in Peiping, Hopei. Since the graduates of this school have more opportunity in training they are naturally expected to share more responsibility. Today many of them are holding very important positions in different parts of China, and some of the graduates who have families of several children are still doing full-time work. Many nursing leaders in other hospitals are from this school. We owe our gratitude to Anna D. Wolf, the first director of the school who laid the foundation, to Ruth Ingram, and to Gertrude Hodgman (the present director of the school) who followed Miss Wolf and who have continued to carry out the nursing education program on a college level.

The third period 1924–1937.—Public health nursing education in China began when the first health demonstration station was opened by the city authorities in coöperation with the Peiping Union Medical College in 1925. The students of the school of nursing of the college and students from other hospitals in Peiping affiliated with the health station. Gertrude Hosmer was the first to organize a public health nursing program in China. A postgraduate course of nine months was offered by the First Public Health Station of Peiping to graduates from different schools of nursing in China. This station is now in charge of Hsu Ai Chu.

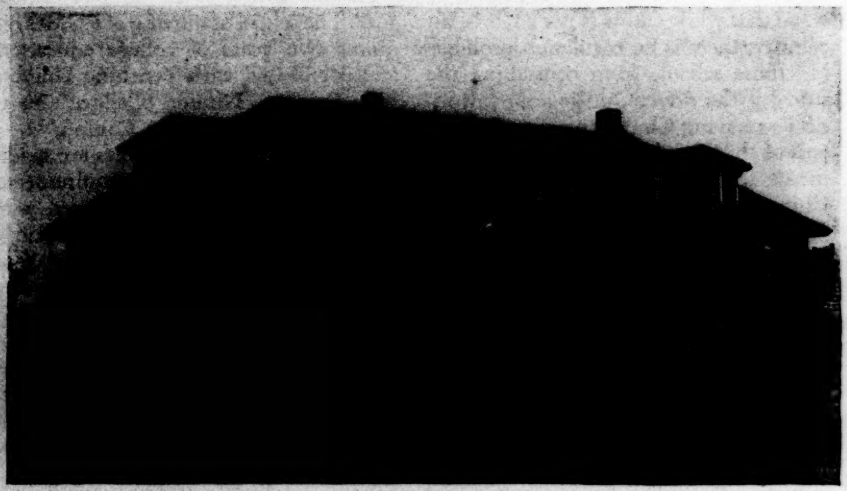
Mrs. Elizabeth Kong Mei was the first to organize public health nursing in Nanking and in Wu Soong, Shanghai.

A few years after the establishment of the First Public Health Station of Peiping, the Central Public Health Station of Nanking was established by the National Health Administration and offered a similar postgraduate course of six months. Since 1934, this course has been given twice a year. Ten to fifteen scholarships are offered each term to graduate nurses by the Ministry of Health, with the understanding that she or he will be willing to go back to the hospital which sent them. Hu Tun-wu is in charge of this teaching program.

Chou Mei-yu started the first rural health nursing course in Ding-hsien, Hopei, about two years ago.

The postgraduate course in institutional nursing was started in PUMC in 1928. Nurses in all parts of China have benefited from this course. Later on Elizabeth M. Pollock and Chang Tsu-hwa of the Union School of Nursing of Margaret Williamson Hospital, Shanghai, offered a similar course. Miss Chang is one of the promising nurses in China. The Ministry of Education also organized a postgraduate course in institutional nursing in connection with the Central School of Nursing, Nanking, in 1936. Ten to fifteen scholarships are given each year by the Ministry of Education to those nurses who will go back to the hospitals which send them for the course. Gertrude Pao is the first traveling instructor to be appointed by the government to teach this course in Peiping, Nanking, and Shanghai.

The Central School of Nursing, Nanking, was established by the government in 1932. The teaching facilities of the classrooms, personnel, clinical material, and living conditions of this school are excellent. Mrs. Bernice Chu Chen is the



NURSES ASSOCIATION OF CHINA HEADQUARTERS IN NANKING

principal of the school and deserves credit for this good work, which we hope will not be irreparably interrupted by the present conflict.

Cora E. Simpson and Miss Hope Bell were appointed full-time general secretaries of the Nurses Association of China during the biennial conference in 1922. The first Chinese secretary of our Association was Mary Shih, appointed in 1928; our first Chinese president appointed at the same time was Lillian Wu. The responsibility of the Association was turned over to the Chinese nurses in that year.

The headquarters of the NAC was moved to Nanking from Peiping in 1930 at the request of the Ministry of Health. Money for the property and building which was later put up for headquarters was contributed by the entire nursing body in China. It was very good of our members to help with the building funds, because their monthly incomes were very low. A new administrative and hostel building was dedicated on June 10, 1937.

The Nurses Association of China was registered with the national government in 1932 and in doing so secured the coöperation and protection of the Government. In 1934, the Association registered with the Ministry of Education, the Bureau of Municipal Government, and the Central Tang Pu. Diplomas have been issued to 6,357 nurses, but we have only 3,009 active members.

In December 1934, the Ministry of Education organized the Central Board of Nursing Education, consisting of nine members—five nursing leaders, and four representatives from the Ministry of Education and Health. The aim of this Board is to centralize nursing education and to standardize the national curriculum. Vera Nieh was the first secretary of the Board.

The legal requirement for registration of schools of nursing was announced in the summer of 1935 and in two years more than forty schools of nursing had completed the procedure of registration. Some schools found it difficult to meet the requirements and others closed rather than register because *Bible* study was not included in the national curriculum. I wish our foreign friends would under-

stand that while China is not a Christian country, there is no regulation prohibiting those schools from continuing the study of the *Bible*. Our government insists on having Chinese nurses as principals of the schools as one of the requirements for registration. They feel that Chinese nurses should begin to stand on their own feet and not be "babied" any longer. Since then every school has been in charge of a Chinese nurse.

The national examination has been turned over to the Ministry of Education and after the first week of January 1938 the national examinations will be conducted by the Ministry of Education. This was planned before the Sino-Japanese conflict.

Prenursing education was discussed during the biennial conference at Hankow in 1934, when it was decided that the background for entrance would be junior middle school graduation. At the present time there are only four schools requiring senior middle school graduation, among which is the Union School of Nursing of the Margaret Williamson Hospital, Shanghai. It is hoped that all schools will have this requirement by 1938. The school of nursing of PUMC requires two years of college education and is affiliated with Yenching University, Peiping, Ginling College, Nanking, and Canton College, Canton.

As in other countries efforts are made at times to lower entrance requirements for nursing education; however, our Chinese nurses believe in high standards and will work together for this end. The need for Chinese nursing leaders is great and can be met only through upholding high standards in nursing education.

The growth of nursing in China has been amazing during the last few years. We are very glad that our government is now taking an interest in its development and has begun to realize that nursing is a real profession. I hope that in the years to come nursing in our country will advance more and more and stand high in the professional world.

References

Stephenson, Gladys E.: *A Short Outline of Nursing History*. Kwang Hsueh (Shanghai), 1936.

Wang, Chi-min and Wu, Lien-teh: *History of Chinese Medicine*. Second edition. Chicago Med. Bk. Co., 1936.

Trends in Extra-curricular Activities

In recent years, extra-curriculum activities (in secondary education) have taken on a respectability and educational standing previously denied them. Student activities have been elevated to a position where it is realized not only that they are here to stay but that they have large educational values.

Sane school administration dictates that student activities shall be recognized for their important potentialities in contributing to educational objectives; that the competitive spirit is strong in young people and should be acknowledged, but should not dominate the extra-curriculum program; that activities should be fostered which have a carry-over value for adult life, but that the pupil also has a right to some activities which have special appeal to his adolescent tastes and consequently may be dropped soon after his schooling is completed; that while supervision of the activities program is in place and necessary it must not be exercised to the point where it robs the program of spontaneity and deprives pupils of opportunity for exercising initiative and leadership; and that school authorities may have full realization of the values of extra-curriculum activities in building school spirit and morale without abdicating from control of school policies.—From *Trends in Secondary Education*, by Carl A. Jessen, Office of Education, United States Department of the Interior, 1937, page 38. U. S. Government Printing Office.

Allergy and the Allergic Patient

By EDNA PENNINGTON, M.D.

ALLERGY means literally "an altered reactivity." It is the term used to denote a state of hypersensitiveness to substances, probably protein in nature, called "allergens." Allergens may be ingested (foods), inhaled (dust and pollen), or harbored in the body (bacteria or fungi). The symptoms which they cause vary in different individuals, but may all be explained upon the basis of localized edema or of smooth muscle spasm, or of a combination of the two.

The allergic individual may no longer take comfort in the assurance that his affliction, though always with him, will never kill him, for he will learn if he attempts to insure his life that allergy constitutes a definite hazard to longevity as well as to health. He will learn that about 70 per cent of "hay fever" sufferers eventually develop asthma and that asthma is not infrequently a direct as well as indirect cause of death.

Recent researches indicate that allergy is far more prevalent than was formerly believed. Vaughan [1] found by surveying a community of 500 people that about 10 per cent of the population were afflicted or had been afflicted with some major allergic disease, but that about 33 per cent were suffering from some "minor allergy," that is, had mild symptoms which he attributed to hypersensitivity. Similar surveys have corroborated his estimates. Pipes,[2] of Shreveport, more recently, in surveying a similar cross section of the population, found even higher percentages of allergy. On the basis of these and other surveys it may be assumed that today from 10 to 30 per cent of the population are allergic.

Allergy may well be described as a "mystery" disease for it presents itself in so many different guises that its identity may be most difficult to establish. The well-known allergic diseases are: bronchial asthma, hay fever, urticaria, infantile eczema, and allergic headaches. Recently it has been recognized that many gastro-intestinal disturbances (cyclic vomiting, diarrhea, attacks simulating appendicitis, spastic constipation), gall bladder syndromes, eczematous skin diseases in adults, and occasionally epilepsy may be allergic in origin and due to sensitivity to foods. In the Vanderbilt University Hospital in the past few years many patients previously considered neurotics and suffering from "nervous indigestion," have been referred to the allergy clinic. Study revealed a considerable number to be allergic and a number of these were entirely relieved of their gastro-intestinal disturbance by the elimination of certain foods from their diet.

Allergists are fairly well agreed that the tendency to be allergic is inherited. Rowe [3] and others state that there is a positive family history of allergy in from 60 to 70 per cent of allergic patients. Many normal people exhibiting no known allergies also give a family history of allergic disease. It seems certain, however, that allergic diseases occur more frequently in patients with family his-

[1] VAUGHAN, W. T.: Minor Allergy. Its Distribution, Clinical Aspects, and Significance. *J. Allergy*, Vol. 5, Jan. 1934, pp. 184–196.

[2] PIPES, DAVID M.: The Evidence of Major and Minor Allergy in the Deep South. *Southern Med. J.*, Vol. 30, Oct. 1937, p. 1,012.

[3] ROWE, ALBERT H.: *Clinical Allergy Due to Foods, Inhalants, Contractants, Fungi, Bacteria, and Other Causes.* Lea, 1937, p. 43.

tories positive for allergy than in those with a negative family history.

The theory of allergy is closely related to that of immunity and may be briefly stated. Specific antibodies becoming attached to the cell bodies make persons hypersensitive. These antibodies, fitting certain allergens as locks do keys, cause something to happen to the allergens which make them toxic. Immunity, which is similar to allergy but practically an opposite condition, is caused by these same antibodies circulating in the blood instead of being attached to tissue cells. Desensitization to allergens occurs when the attached antibodies are broken off the cells to become circulating antibodies or are outnumbered by circulating antibodies.

The Nature of Allergens

Allergens, which are the substances to which patients become hypersensitive, are probably protein in nature although there is evidence to show that some are polysaccharides which combine with proteins in the body. It might seem at first thought that patients could be sensitive to almost anything, which would mean a bewildering number of allergens. It has been shown, on the contrary, that about 80 per cent of allergic diseases are caused by twenty common allergens.

Practically speaking, it is sufficient for the average patient to be tested to the common foods that he eats and twenty or thirty inhalants, half of which are pollens. One well-known allergist tests routinely to twenty common allergens, including only a few representative staple foods, adding others as especially indicated. Other allergists test with from sixty to 150 common foods and inhalants, only a few carrying the number of tests to three or four hundred.

In our experience the use of forty-two routine tests serves as a practical basis for determining the allergen or allergens to which the patient is sensitive.

These allergens are listed as follows:

apple	cottonseed
lettuce	turnip
wheat	banana
house dust	ragweed mixture
milk	red snapper
beef	pyrethrum
tobacco	wool
peanut	chocolate
cattle hair	pork
codfish	carrot
peach	feathers
grape	egg
glue	onion
cornmeal	horse dander
tomato	cabbage
orris	flaxseed
cherry	grass mixture
orange	silk
strawberry	dog hair
I. potato	rabbit hair
string bean	green peas

If tests with the above are negative, experience indicates that further testing, in the majority of instances, will prove of little value. If, on the other hand, positive reactions result, these are used as indications for testing the patient with other related allergens.

It may be interesting to consider briefly the method employed for obtaining the allergens or protein extracts used for skin testing. These substances are obtained in the simplest way possible from the materials with which the patient is in contact in real life.

The protein substances must be extracted in saline or glycerine solution, kept pure, and made sterile. The protein content of the allergenic substance is first extracted with saline in proper proportions to which glycerine is added for its preservative properties. This extract is then filtered through a fine porous filter to remove precipitates and to make it sterile. All fatty materials are best removed because they interfere with the extraction of the protein and cause the testing materials to become rancid more easily. After culturing for sterility and standardizing to maintain constant

strength, the extract is ready to dilute to the proper strength for skin testing.

Diagnosis of Allergic Diseases

Success in the treatment of the allergic disease depends on finding the allergen, or allergens, to which the patient is hypersensitive and which are causing the symptoms for which he presents himself. Diagnosis and treatment, briefly, include three or four definite steps: (1) a detailed history (patient's symptoms, survey of environment and habits, conditions which seem to aggravate or allay his symptoms, et cetera); (2) skin testing; (3) elimination of the offending allergens from the environment; or (4) desensitization.

Skin testing is usually the most valuable short cut and guide to a diagnosis. Fortunately for us, injections of small quantities of extracts of various allergens into the skin of hypersensitive patients are usually followed by immediate urticarial reactions at the site of injection. After testing for the common foods and inhalants, all of the substances to which the patient reacts positively are eliminated from his diet and environment.

After the patient becomes free of symptoms the offending foods or inhalants are added back one at a time and the patient's reaction to them carefully checked. For example, wheat and pork are eliminated from patient A's diet and feathers from his environment. He is relieved of symptoms. Then wheat is added again to his diet; if his symptoms do not reappear in some four or five days, pork is added to his diet. If his symptoms appear on the addition of pork to his diet, it is again omitted and his response noted. The relative importance of the three allergens giving positive skin tests is thus determined.

Classification of Allergens

Allergens known to cause allergic diseases may be divided for classification and discussion into several groups: foods or ingestants, inhalants, contact substances, bacteria, and fungi.

Foods.—Foods have in the last few years become recognized as causing all types of allergy. Children are most frequently sufferers from food allergy, but almost every adult sufferer from allergy is sensitive to one or more foods. Although the more staple foods, especially wheat, milk, and eggs are the major offenders it is necessary to skin test for and investigate all the common foods which a patient eats—for an adult a hundred or more in number. From the forty-two allergens listed above, an adequate basic diet can usually be selected, consisting of foods negative to skin test and not causing symptoms.

Sometimes various trial diets are necessary, foods being added later for trial one at a time after the patient is symptom free. After omitting harmful foods from the diet the allergic patient tends to lose his sensitivity to them and hence they may gradually be included again in his diet after a few months. In children, desensitization to the important foods by mouth is often successful, beginning with perhaps very minute quantities and gradually increasing the amount over a period of months until a reasonable quantity is tolerated. This method is frequently employed in egg-sensitive children where at times a drop of egg white is placed in a glass of water, and one drop of that first administered.

Inhalants.—Inhalants, or substances which are breathed into the body, have long been recognized as an important cause of allergic disease. In fact, for centuries, plants were the only known causes of asthma and hay fever.

Inhalants may be further subdivided into pollens, epidermals or animal danders, house dust, and miscellaneous substances.

Pollens which cause allergic diseases include those pollens or plants which de-

pend on the wind and not on insects for pollination. The plants in question must grow profusely and be so widely distributed that large quantities of pollen are thrown into the air. It is interesting to note that the sufferer who fancies himself the victim of "rose fever" really is a victim of grass pollen which is present in large quantities in the air from April to July. Similarly the sufferer who thinks of himself as having "goldenrod fever" may actually be suffering from exposure to the pollen of the ragweed and wormwood, which is present in the air from August fifteenth until frost. Tree pollen may cause hay fever or asthma from February to May or June. Ragweed pollen is probably the largest single cause of allergic disease and most seasonal hay fever sufferers are sensitive to it. In the West and Southwest, the sage and Russian thistle pollens, rather than ragweed, are major causes of pollinosis. Both preseasonal and coseasonal treatment with pollen is usually possible and successful.

Animal danders are potent and frequent causes of allergic disease. They include feathers, to which almost everyone is exposed in the form of pillows, eiderdown comforts, chickens, or pet birds; wool found in blankets and fabrics; dog dander, cat dander, as well as the dander from horses, cattle, hogs, and various other animal hairs used in furs and fabrics.

House dust is indeed an important and universally present cause of allergic disease. Possibly 50 per cent of allergic sufferers are sensitive to house dust and have symptoms therefrom. Since dust can seldom be completely avoided it is fortunate that desensitization with it is usually successful.

Orris root, the component of most face powders, perfumes, and scents are likewise a major offender. Since one cannot get away from this in the social and business world it is usually also necessary and possible to desensitize to this ever-present allergen.

Tobacco smoke, pyrethrum used in insect spray, powdered glue from furniture and old books, various flowers used in industries, raw silk, insect emanations, and other inhalants are rarer causes of allergic disease and may usually be avoided. If this is not possible, the sufferer may be desensitized. In fact, desensitization to inhalants is usually successful.

Contact substances.—Contact substances are important only in causing dermatitis. Eruptions of the skin on any exposed surface may be due to hypersensitivity to some substance which the patient touches. The lesions are characterized by redness, itching, and the formation of vesicles. The contact dermatoses often cannot be distinguished in appearance from allergic dermatoses due to hypersensitiveness to inhalants, foods, or fungi.

Bacteria.—There is some controversy over the mechanism or even the existence of bacterial allergy. Nevertheless, there is a tendency among some medical practitioners to assume that allergic disease, particularly asthma, is usually bacterial in origin. This erroneous concept is due to the fact that many patients relate the onset of their trouble to an attack of "cold," pneumonia, or acute bronchitis. Many patients with bronchial asthma, moreover, suffer from secondary infections such as chronic sinusitis, chronic bronchitis, and bronchiectasis. Allergic rhinitis and bronchial asthma frequently masquerade as upper respiratory tract infections—indeed, an allergic subject's respiratory infections may serve as the trigger mechanism for the production of the first allergic symptoms. Infection in the paranasal sinuses and bronchi is a frequent complication of primary inhalant or ingestant allergy.

Certainly more detailed and expert study of patients is decreasing the num-

ber of asthmatics relegated to the "intrinsic" or infection class. It is no longer safe to assume that bacterial allergy is the sole cause of an allergic disease simply because no other factor can be readily demonstrated. It is to be borne in mind, however, that patients can and do become sensitive to bacteria. The latter are largely protein in nature and sound experimental evidence indicates that true bacterial allergy does exist, especially as a secondary development or complication of "extrinsic" allergy.

Fungi.—Fungus infection and fungus sensitivity are recognized as playing an important rôle in the production of respiratory, skin, and allergic diseases. Fungus infections are being recognized more frequently than heretofore.

Trichophyton, monilia, and similar organisms are ubiquitous inhabitants of skin and nails and may give rise to a great variety of abnormal conditions. Allergy to these fungi has been shown to result in the development of dermatoses, allergic rhinitis, and even bronchial asthma in the same way that other allergens do (Sulzberge,[4] Pennington[5]).

New knowledge concerning hypersensitiveness to inhaled fungus spores is apparently developing and is receiving support from several quarters. Feinburg[6] and Durham,[7] have found that the spores of a fungus called Alternaria are found in the air during the summer, often in larger quantities than ragweed. Feinberg believes that a large number of patients have asthma and hay fever due to fungus spores, especially during the hot weather. Our own spore counts and clinical findings corroborate these conclusions, although we are unwilling at this stage of our study to attempt an estimate of the relative importance of these air-borne fungi as allergens. It seems likely that with this new group of allergens we may find the cause of hypersensitiveness in at least some of the allergic patients in whom we have as yet demonstrated no etiologic factor.

[4] Sulzberger, M. B., and Wise, Fred: Ringworm and Trichophytin. *J.A.M.A.*, Vol. 99, Nov. 1932, pp. 1,759–1,764.

[5] Pennington, E. S.: Trichophytin and Monilia Extracts in Allergic Dermatoses, *J. Allergy*, Vol. 7, Nov. 1935, pp. 54–63.

[6] Feinberg, S. M.: *Seasonal Hay Fever and Asthma Due to Molds.* *J.A.M.A.*, Vol. 107, Dec. 5, 1936, pp. 1,861–1,867.

[7] Durham, O. C.: *Incidence of Air Borne Fungus Spores. I. Alternaria.* (In preparation for publication.)

Treatment of Allergic Disease

After the cause of the allergic disease has been discovered the treatment is based upon two principles: (1) the patient is trained to avoid offending foods and inhalants; (2) where avoidance is impossible or impracticable, desensitization or hyposensitization is attempted.

Desensitization to inhalants, bacteria, and fungi is accomplished by the simple expedient of injecting, just under the skin, small and gradually increasing quantities of the allergen to which the patient is sensitive. Care is taken to keep the amount injected less than that amount which is sufficient to cause symptoms. By increasing the quantity gradually the tolerance of the patient is increased. Theoretically the allergen unites with some of the specific antibodies fixed to the tissue cells, reduces their number, and thus renders the cells less sensitive to subsequent exposure to the allergen. When enough allergen has been injected to unite with all the antibodies, desensitization is theoretically complete.

A spontaneous reduction in sensitivity to foods tends to follow prolonged abstinence from them. When this occurs the offending foods may be added slowly to the diet in gradually increasing quantity.

Treatment of allergic diseases is more successful than is realized by the average doctor, nurse, or layman. Treatment of bronchial asthma, which is perhaps the major allergic disease, is successful, according to different estimates, in from 50

to 75 per cent of cases. The term "successful result" implies that the patient is greatly improved and is able to pursue a normal life without significant difficulty. In the majority of instances, however, successful treatment requires that the patient live within certain environmental and dietary restrictions. The average patient must remain under the observation and care of an allergist for some time and it should be remembered that hypersensitiveness to heretofore non-offending substances may develop.

The treatment of seasonal hay fever by competent allergists is successful in from 75 to 90 per cent of cases. After three years of treatment permanent relief is obtained in perhaps 50 per cent of patients.

Convincing statistics relative to treatment results in migraine, urticaria, and allergic dermatoses are not available. It seems probable, however, that the specific treatment of these diseases may prove as successful as for hay fever and asthma.

Nursing the Allergic Patient

By HARRIET KLEIN, R.N.

Because of the prevalance of allergy and the important rôle which environment plays in the control of symptoms, it is desirable, if not essential, that the nurse be well informed concerning both the etiology and the manifestations of the disease. The activities of the nurse in regard to the care and treatment of these patients is necessarily limited. Nevertheless, she must have an intelligent understanding of the factors involved if she is to coöperate effectively with both the patient and the physician in uncovering the causes and in allaying the severity of the manifestations—reactions which definitely interfere with the social usefulness of the individual.

The brevity of this article precludes a detailed discussion of the nursing care indicated in all the various forms of allergy, such as, migraine, eczema, et cetera. For practical reasons, only salient points will be presented.

In the Hospital

Because the allergic manifestations in asthma are often more severe and more crippling than they are in the other allergic diseases, the asthmatic is the type of hypersensitive patient most often encountered on the hospital wards.

Hospitalization of the patient with bronchial asthma is usually done for the purpose of placing him in a controlled environment and, thus, either to try to find the factors causing the symptoms, or to afford the patient temporary relief from the causative allergens during an unusually severe or protracted attack. Hospitalization is important for purposes of treatment only as a palliative measure—to tide the patient through an emergency. A perfectly controlled environment is not permanently available and therefore has little practical value from the standpoint of prolonged therapy. Its value as a method of treatment or as a diagnostic aid is primarily dependent on the constant and untiring vigilance of the nurse who has charge of the patient.

The nurse then, in addition to carrying on the activities necessary for effective bedside care, must assume another and equally important responsibility in

providing a suitable environment for the patient. The nursing of the asthmatic therefore will be discussed under two headings, environment and general nursing care.

Environment.—Since dust and smoke may precipitate attacks in the hypersensitive patient, he should be placed in a spot which affords maximum protection from smoking chimneys, dust from a main artery of traffic, et cetera.

His immediate environment, also, must be kept meticulously clean. All furniture, floors, light fixtures, moldings, door and window casings must be frequently and carefully washed. While one or two small washable rugs may be permitted, it is best to eliminate draperies as they are difficult to keep free from dust. Flowers and plants also have no place in the allergic patient's room. Comparative freedom from molds may be assured if the room is sunny and dry.

Since 1925, several investigations have been made on the effects of temperature, humidity, and air filtration upon bronchial asthma. Striking relief was obtained through air filtration for patients suffering from pollen asthma. Low temperatures seemed to make the patient with bacterial asthma worse. No conclusive evidence was found that damp air is more harmful than dry, but the consensus of opinion seems to be that patients are more comfortable in a relatively dry atmosphere. A very dry atmosphere such as that caused by modern methods of heating often aggravates asthmatic symptoms. In general, it may be said that the room should be well ventilated, but warm, avoiding extremes of temperature, and free from draughts.

The air filter is a useful palliative device used to keep the room free of pollens. It is placed in the window and consists of a motor-driven suction fan attached to a sheet-metal box which holds the filters. Pollen-free air is thereby sucked into the room at a rate of approximately 150 cubic feet per minute. It is, of course, important to keep all doors and windows tightly closed.

Since allergens to which the patient is sensitive may be present in fur-trimmed and woolen clothing of friends and relatives, visitors should be restricted, at least until the etiological factors have been determined.

It is also well to remember that these unduly sensitive patients not infrequently react to insecticides, or rather, to the pyrethrum which most of them contain, and also to certain types of cosmetics. The thoughtful nurse, therefore, bars their use during the patient's stay and provides herself with allergen-free cosmetics.

Much thought should be given to the patient's bed and bed clothing. As so many patients react to feathers, horsehair, and wool, a cotton mattress, cotton blankets, and an air-filled pillow should be provided. If an air pillow is not available, a feather pillow which is carefully and completely covered with rubberized sheeting will serve equally well, providing the cover is inspected at frequent intervals for worn places or gaping seams. Pillows and mattresses filled with kapok should be used cautiously. Recent investigations have shown that kapok deteriorates rapidly and in a few months becomes a potent source of dust.

General nursing care.—Since the asthmatic patient is usually observed in the clinic for very brief periods at a time, it is not possible for the physician to study all his needs in minute detail nor, in all instances, to make a meticulously detailed investigation of his habits. The nurse, because she spends much time with the patient, can discover what his mode of life is and help him to revalue such routine hygienic measures as proper rest, an adequate diet, proper elimination, et cetera. The patient, because of the chronicity of his illness, may know a great deal about the cause of his paroxysms and yet know

very little about healthful living. Unless he is not only well informed concerning his allergic condition but also able to fortify that knowledge with sound health principles, results of treatment and permanent well-being will be constantly jeopardized.

Nervous and mental factors in the etiology of bronchial asthma are no longer considered as important as they once were, though it has been found that protracted worry or emotional stress may cause asthma in the predisposed individual. Sudden emotional crises, such as fright or excitement, may precipitate an acute paroxysm in some and halt it in others. In view of these findings, the emotional reactions of the patient should not be underestimated. If the nurse has the necessary armamentarium of intelligence, understanding, and skill, she will do much to provide a setting for her patient conducive to mental relaxation and contentment.

The general measures during an attack are mainly to provide rest, a suitable diet, and certain drugs.

To facilitate relaxation and a maximum amount of comfort, the bed should be provided with back and knee rests. The patient, as a rule, is dyspneic and unable to lie flat even between attacks. Continuous rest in bed is not necessarily indicated, however, since it is difficult to maintain with comfort the position which the asthmatic characteristically assumes. When breathing is difficult he leans forward with shoulders hunched, thus placing his legs in a very uncomfortable position. For this reason, a comfortable, well-padded armchair (leather covered to ensure cleanliness) should be provided to which the patient may be moved whenever he becomes weary and cramped from his awkward position in the bed. A sturdy table on which a pillow is placed may be set before the chair in order that he may find proper support when assuming the leaning-forward position. Because undue exertion and overfatigue have a tendency to induce asthmatic attacks, the promotion of rest, no matter how obtained, whether in the chair or in the bed, is an extremely important objective in the nursing care of the patient and often requires much ingenuity and skill.

Since the patient usually perspires profusely at these times, it is important to prevent chilling and subsequent colds. Outing flannel pajamas are preferable to muslin ones for this reason. If the patient makes much use of his chair, he should be kept warm by the additional use of socks and a blanket.

The elimination diet, as originally outlined by Rowe, is commonly used in the diagnosis and treatment of allergic conditions. Since most commonly eaten foods are the worst offenders, such foods as wheat, eggs, milk, fish, raw fruits, raw or uncooked vegetables, beans, peas, nuts, chocolate, spices, and condiments are avoided. Neither are unusual foods, closely related biologically to the common foods, included. The patient is kept on this diet for at least two weeks and, if no new symptoms arise, new foods are added one at a time and not more than two new foods each week.

The ingestion of solid food often increases discomfort during paroxysms and a restricted diet is often self-imposed. The nurse should, however, encourage the patient to take plenty of water, hot tea, and coffee, as these are usually well tolerated.

After the subsidence of symptoms, the patient is gradually returned to a fuller diet. Heavy meals are interdicted. It is best for the asthmatic to eat smaller meals more frequently. The most substantial repast is served at noon and no solid food is allowed after a light evening meal.

The drug therapy consists of epinephrin, ephedrin, the inhalation of some stramonium leaf mixture, sometimes catharsis and, in very rare instances, mor-

phine. These medications are effective in most cases of bronchial asthma, regardless of etiology.

The most valuable drug in this group and the one which will alleviate an attack more quickly and with fewer unpleasant side effects is epinephrin. It is administered subcutaneously or intramuscularly. Violent headaches, severe vertigo, palpitation, tremor, breathlessness, precordial pain, nausea and vomiting may follow accidental intravenous injection. It is, therefore, important to withdraw the plunger slightly after the needle has been inserted, to ascertain whether a blood vessel has been entered. The effects of epinephrin are transitory and it may therefore be given as often as every thirty minutes. Large doses in the average attack are of no more benefit than small doses of three to six minims. If small doses are given early in the attack, severe symptoms may be controlled.

Ephedrin may be administered orally, but may cause very unpleasant reactions and is of little value in controlling an acute paroxysm. It may, however, prevent attacks.

Morphine is used only in rare and unusual situations, as when exhaustion is very severe and rest becomes imperative. The more severe the attack, the more dangerous, as a rule, is the use of morphine, since it depresses respiration and the cough reflex. Ether in oil, as a retention enema, is more satisfactory.

Occasionally atropine is administered with morphine. This also may aggravate symptoms since it dries up secretions and makes expectoration difficult.

Catharsis is important in unusually severe or protracted attacks as, in some instances, the precipitating cause of the attack was a heavy meal. Active catharsis need not be continued after the paroxysm has subsided, but the bowels should be kept open.

Counterirritants such as mustard paste, flaxseed, et cetera, are not ordered routinely. In many instances they aggravate the symptoms, since hypersensitiveness to these substances is common, especially in children.

Between attacks a sensible, hygienic regimen should be observed with special reference to rest, diet, elimination, and avoidance of exposure to cold. Inasmuch as the patient may become chilled during or following his bath, special precautions should be taken to see that both the water and the room are comfortably warm and that he is properly protected in cold corridors if he is allowed to take tub baths. The brand of soap, bath salts, or tooth paste used should routinely be approved by the physician before they are allowed.

In the Clinic

To know the emergencies that may arise in the allergy clinic, and to be prepared for them, is a nursing responsibility common to all clinics, however diverse the other duties may be. Those emergencies that may be expected and for which adequate preparation should be made are the constitutional reactions in a hypersensitive patient following treatment or testing.

While these systemic reactions are comparatively infrequent, they may occur and are occasioned more often by treatment than by testing. The reaction may come on immediately or during the first hour after the test or injection that causes it. Delayed reactions occur from one to several hours or days later, and while they are uncomfortable, are seldom serious. General reactions vary greatly in intensity and any combination of symptoms may occur.

The most common systemic reactions are: coryza, cough, asthma, urticaria, pruritus, and erythema. The symptoms less frequently met in constitutional reaction syndromes are: headache, nausea and vomiting, fever, fainting, abdominal

pain, uterine spasm and bleeding, diarrhea, and vertigo.

For effective treatment, the early recognition of an approaching systemic reaction is of utmost importance. Itching of the palms of the hands, the skin, or mucous membranes; coughing; et cetera; are significant. Incidentally, it should be borne in mind that fainting may be caused by timidity and nervousness as well as by an allergen.

The patient experiencing a constitutional reaction should be placed in the reclining position at once, with head and shoulders elevated. A subcutaneous injection of epinephrin, three to fifteen minims, will usually control the symptoms. A tourniquet should be placed above the site of the injection, and part of the dose of epinephrin injected at the site of the skin test or therapeutic injection, and the rest elsewhere in the body. When symptoms begin to subside, the tourniquet may be loosened at intervals of thirty to sixty seconds to allow the gradual absorption of the allergens into the circulation.

In the Home

For proper diagnosis and treatment, the study and supervision of the hypersensitive patient in his home or occupational environment is a valuable and indispensable aid to the physician.

Home visits should be made after the etiological factors have been fairly well determined, so that the nurse may make an intensive search for the causative allergens primarily, and incidentally for others.

Investigating the environment.—All the factors which make for an allergen-controlled environment in the hospital, as discussed previously in this paper, may be applied to the home. In making a search for allergens in the home, however, we should not limit ourselves to the main living-rooms only. Investigation of the storerooms, closets, attic, and cellar is important. If the patient is susceptible to house dust, molds, or insecticides, their presence even in a little-used room may cause symptoms.

Cotton blankets, quite satisfactory in the hospital, are not always so in the home. Houses are not, as a rule, as well heated as hospitals and cotton blankets are not warm enough in a cold climate. Also, blankets are washed frequently in the hospital and can be kept dust free. This is not necessarily true in the home. It is, therefore, more satisfactory, especially if laundry facilities are limited, to advise the patient to cover the woolen blanket with muslin which can be removed and washed more conveniently than the blankets.

It is imperative, in order to make an effective investigation, to know what goes into the manufacture of common household articles. It is not difficult to eliminate the more obvious causes, such as the removal of the cat if the patient is sensitive to cat hair, or the canary if the patient is sensitive to feathers. It is the hidden constituents of articles in the home that elude the investigator and continue the symptoms in the patient. For instance, the upholstery of chairs and davenports may contain horsehair, goat hair, wool, rabbit hair, sawdust, and straw. Rugs may contain wool, dog hair, goat hair, camel's hair, hog hair, and cattle hair. Curtains and draperies are usually made of goat hair, wool, silk, or cotton. Linens of all types are usually made of flax. Wall paper, books, and furniture are important sources of glue dust. Paints, oil cloth, and linoleum contain cottonseed and linseed. Search for the hidden enemy in the complex environment may not always be successful, but it is always intriguing.

House dust, which represents emanations and powdered materials from the upholstery, rugs, draperies, mattresses, et cetera, is often used for hyposensitization treatment of the patient. A vacuum

cleaner for collecting dust specimens is most efficient. When dust is to be obtained from a mattress or from stuffed furniture, the article should first be lightly beaten to bring the dust to the surface. Individual specimens of house dust should be placed in paper bags and labeled.

In addition, in making the investigation, the home surroundings should be noted, namely proximity to stables and poultry yards, the neighboring vegetation, et cetera.

Instruction of the patient.—The results expected from treatment are largely determined by the intelligent coöperation of the patient. Detailed investigation should be made of housekeeping methods and instructions should be given, when indicated, on proper cleaning methods, the storage of clothing, and the value of sunshine and air in preventing the growth of molds.

Since many hypersensitive patients are allergic to certain foods, it is important to teach the patient how to keep a food diary. This should always be done when he is placed on any type of an elimination diet. For convenience, and greater accuracy printed forms for this purpose are issued by the clinic.

Recipes suitable for patients on wheat-free, milk-free, and other types of diets, are available in several textbooks on the treatment of allergy.

Since a small dose of epinephrin given early often serves to abort a serious attack, the patient should not have to wait for the physician to administer the drug, but should be taught to do this himself. The nurse should help the patient to equip the tray, should use this tray to demonstrate the procedure, and then assure herself that the patient can carry out the procedure unassisted. In addition to knowing how to administer epinephrin, the patient should know something about the drug and its action and how to care for it.

Dangers attending the use of patent medicines should be explained, since they have been known to contain ingredients which are actually harmful to the patient and may, in some instances, precipitate attacks.

The well-informed and interested nurse will find many opportunities for stimulating the patient to acquire an intelligent understanding of his condition and will help him to live within the limitations his handicap imposes.

The nurse of the past confined her activities almost exclusively to the curative field—she was trained in her thinking and in her technics to see the patient only in the narrow confines of the sickroom. Her contribution to health was in keeping with the sociological and medical advance of her time. Today, however, with the progress being made in diagnostic and treatment facilities, a new intelligence and a new point of view is imperative. These new nursing needs are exemplified in the field of allergy—a field still in its infancy, but prognostic of the opportunities all branches of health work will offer to the nurse of the future.

Bibliography

Balyeat, Ray M.: *Allergic Diseases: Their Diagnosis and Treatment.* Third edition, revised and enlarged. Davis, 1930.

Coca, Arthur F.: *Hypersensitiveness, Anaphylaxis, Allergy.* (Asthma and Hay Fever in Theory and Practice.) Thomas, 1931.

Gay, L. N.: The Treatment of Hay Fever and Pollen Asthma by Air-conditioned Atmosphere. *J. A. M. A.*, Vol. 100, May 6, 1933, pp. 1,382–1,385.

Hansel, French K.: *Allergy of the Nose and Paranasal Sinuses.* Mosby, 1936.

Rackemann, Francis M.: *Clinical Allergy; Particularly Asthma and Hay Fever; Mechanism and Treatment.* Macmillan, 1931.

Rowe, Albert H.: *Food Allergy: Its Manifestations, Diagnosis, and Treatment with a General Discussion of Bronchial Asthma.* Lea, 1931.

Vaughan, Warren T.: *Allergy and Applied Immunology.* Mosby, 1931.

Wagner, H. C., and Rackemann, F. M.: Kapok, Its Importance in Clinical Allergy. *J. Allergy*, Vol. 7, March 1936, pp. 224–233.

Physics and Modern Nursing

By CARLETON J. LYNDE, PH.D.

THE DRINKER RESPIRATOR is an air-tight metal chamber in which the patient is placed, with his head outside and with a soft air-tight rubber collar about his neck. The respirator is used for patients who, because of paralysis of the muscles controlling respiration, or for some other reason, are incapable of maintaining normal respiration. By means of a motor, part of the air is pumped out of the chamber and returned to it at the intervals of natural breathing.

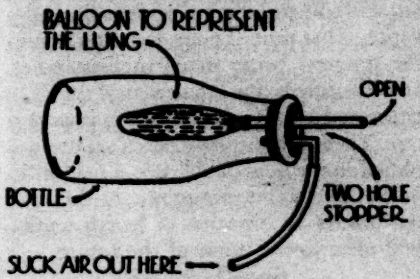


FIGURE 1.—ILLUSTRATING THE WORKING OF THE DRINKER RESPIRATOR

The vasculator, an apparatus used in restoring circulation to extremities whose normal circulation is impaired, is an air-tight glass cylinder about two feet long and one foot in diameter, with a rubber collar at one end which makes an air-tight joint about the patient's leg. As in the respirator, part of the air is alternately pumped out and returned to the cylinder. The principles of physics on which the action of the vasculator depends are essentially the same as those which control the use of the respirator.

It is desirable at this point to explain that the atmosphere of the earth is attracted by the earth and hence has weight. The atmosphere exerts a pressure of 14.7 pounds on each square inch of everything on the earth's surface at sea level. For convenience this is designated here as 15 pounds per square inch.

Boyle's law states: "The pressure exerted by a gas in a vessel is directly proportional to the amount of gas in the vessel." For example: If, at the beginning, a respirator or vasculator is open to the atmosphere, air will enter or leave the appliance until the air pressure inside is equal to that of the atmosphere outside, namely, 1 atmosphere.

If now the appliance is closed air-tight and 1/10 of the air is pumped out, the air pressure inside is 1/10 atmosphere less than 1 atmosphere, that is, the *negative* pressure is 1/10 atmosphere.

If, however, air is pumped into the appliance until it holds 1/10 more than it did when it was open, the pressure inside is 1/10 atmosphere greater than 1 atmosphere. That is, the *positive* pressure is 1/10 atmosphere.

A vacuum, strictly speaking, is a space in which there is no gas whatever. Such a space has never yet been obtained. A vacuum, as we ordinarily use the term, is any space in which there is less gas than there would be if the space were open to the atmosphere. A vacuum exerts a pressure less than that of the atmosphere and the greater the vacuum the less the pressure.

We return now to the respirator and the vasculator. When part of the air is removed from the air-tight chamber of the respirator in which the patient's body rests, the air pressure on the patient's body is decreased and the atmosphere outside the tank fills his lungs by

forcing air in through his nose, mouth, and trachea.

When the air is returned to the tank, the air pressure inside becomes equal to that of the air pressure outside and the natural contraction of the patient's lungs forces air out.

The working of the respirator can be illustrated very simply (Figure 1). Suck air out of the bottle and the atmosphere outside fills the balloon. Let air into the bottle again and the natural contraction of the balloon forces air out.

In the vasculator, air is pumped out of the cylinder at intervals until the *negative* pressure is about 6 inches of mercury, or 3 pounds per square inch. Then it is pumped in until the *positive* pressure is about 3 inches of mercury or 1½ pounds per square inch. (Negative pressure is any pressure less than 1 atmosphere. Positive pressure is any pressure greater than 1 atmosphere.)

During negative pressure, the atmospheric pressure on the body outside the vasculator forces blood from the body into the leg and foot which is enclosed in the vasculator. During positive pressure, the reverse phenomenon takes place.

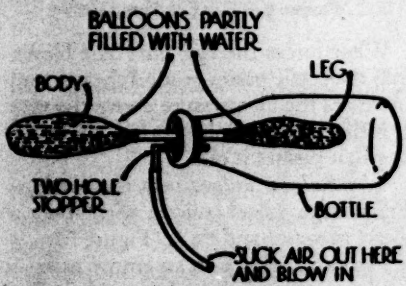


FIGURE 2.—ILLUSTRATING THE WORKING OF THE VASCULATOR

The working of the vasculator can be illustrated simply and clearly (Figure 2). A round, five-cent, balloon partly filled with water represents the body outside the vasculator. It is connected by a glass tube with a long (two for five cents) balloon which represents the leg and foot inside the vasculator.

Suck air out of the bottle and the atmospheric pressure outside will force water from the round balloon into the long balloon. Blow air into the bottle and the reverse operation will take place.

DEMONSTRATIONS OF AIR PRESSURE

The atmosphere crushes the can.— Find an empty *gallon* can with an air-tight cork or screw top (Figure 3). Pour a tumbler of water into the can, place it *open* on the stove and boil the water until the steam has issued for 1 minute or more.

From Lynde, Carleton J., "Science Experiences With Home Equipment." Scranton: International Textbook Company, 1937.

FIGURE 3.—THE ATMOSPHERE CRUSHES THE CAN

Turn off the gas, cork the can, invert it and place it in a pan of water with the cork under water. The can will collapse.

Put the *closed* can on the stove again, light the gas and let the steam blow the can nearly to its first shape. Turn off the gas before it goes too far.

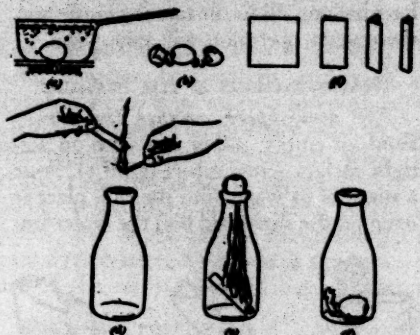
What is the force that crushes the can? The atmosphere of the earth is attracted by the earth and hence it has weight. It exerts a pressure of 14.7 pounds on each square inch of everything at the earth's surface, at sea level. We will call this pressure 15 pounds per square inch.

When water is boiled in the can, the steam fills the can and drives nearly all the air out.

When the gas is turned off, the steam condenses to water in the can and leaves nearly a complete vacuum which exerts

practically no pressure outward. The atmosphere outside exerts a pressure inward of 15 pounds on each square inch and crushes the can.

When steam is generated in the can again, the steam pressure in the can be-



From Lynde, Carleton J., "Science Experiences With Home Equipment." Scranton: International Textbook Company, 1937.

FIGURE 4.—THE EGG POPS IN

comes greater than that of the atmosphere outside; it forces the sides of the can outward.

The egg pops in.—Boil a fresh egg ten minutes (Figure 4); place it in cold water ten seconds and remove the shell.

Fold a single sheet of toilet paper three times in the same direction.

Light the paper at the lower end.

Drop the lighted paper into a quart milk bottle and place the shelled egg in the mouth of the bottle. The egg will pop into the bottle.

What pushes the egg into the bottle? The air in the bottle at first is open to the atmosphere and it exerts a pressure outward equal to that of the atmosphere inward, namely, 15 pounds per square inch.

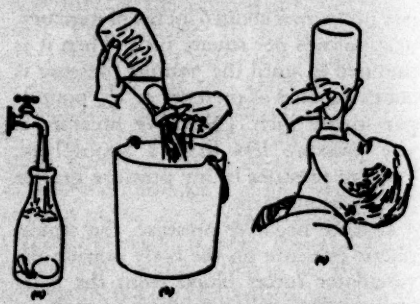
When the burning paper is dropped into the bottle, the heat of the burning paper expands the air in the bottle to about three times its normal volume, hence it forces two-thirds of the air out of the bottle. When the remaining one-third cools (as the paper ceases to burn) and contracts under the egg, its outward pressure is only ⅓ x 15 pounds, or 5 pounds per square inch.

The atmosphere outside forces the egg into the bottle against this low pressure.

The egg pops out.—Fill the bottle with water (Figure 5); invert it; hold the egg up with your finger and rinse out the burned paper.

Lean your head back *until your face is horizontal*, press the bottle mouth *firmly* over your own mouth and puff *hard* into the bottle.

Lift the bottle and the egg will pop out. Be ready to catch it!



From Lynde, Carleton J., "Science Experiences With Home Equipment." Scranton: International Textbook Company, 1937.

FIGURE 5.—THE EGG POPS OUT

What forces the egg out? Air blown into the bottle passes around the egg and increases the air pressure above the egg. It is this increased air pressure above the egg that pushes it out.

The balloon bulges into the bottle.—Fill a large round balloon with about a quart of water and tie it (Figure 6).

Place the balloon in an empty pail.

Light a folded piece of paper (4 inches square before folding); drop it into an empty quart milk bottle and quickly press the mouth of the bottle against the balloon.

Part of the balloon will move up into the bottle.

What forces the balloon into the bottle? The pressure of the air in the bottle is reduced to about 5 pounds per square

inch, as in the experiment with the egg, and this is the pressure on the part of the balloon covered by the mouth of the bottle.

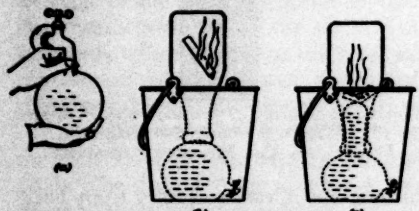
The pressure of the atmosphere on the balloon surface outside the bottle, 15 pounds per square inch, forces part of the balloon into the bottle against this low pressure.

Fill the bottle to the top with water to wash out the burned paper.

Your palm bulges into the bottle.—Fold a piece of paper (4 inches square) three times in the same direction and light it at its lower end (Figure 7).

Drop it into a quart milk bottle, turn the bottle on its side and press your palm against the mouth of the bottle. You will feel your palm bulging into the bottle.

What forces your palm into the bottle? The pressure of the air in the bottle is reduced to about 5 pounds per square inch; this is the pressure on the part of your palm covered by the mouth of the bottle.



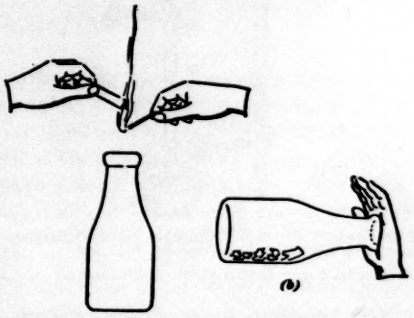
From Lynde, Carleton J., "Science Experiences With Home Equipment." Scranton: International Textbook Company, 1937.

FIGURE 6.—THE ATMOSPHERE FORCES PART OF THE BALLOON INTO THE BOTTLE

The pressure of the atmosphere on the remainder of your hand and body, 15 pounds per square inch, forces your palm into the bottle.

MEASURING ATMOSPHERIC PRESSURE

A glass tube 36 inches long and closed at one end is filled to the top with mercury which drives out the air (Figure 8). A finger is then placed over the open end and the tube is inverted into an open dish of mercury. When the finger is removed from the open end under mercury, the mercury in the tube sinks until its height is about 30 inches above that in the dish, and it leaves nearly a perfect vacuum at the top of the tube.



From Lynde, Carleton J., "Science Experiences With Home Equipment." Scranton: International Textbook Company, 1937.

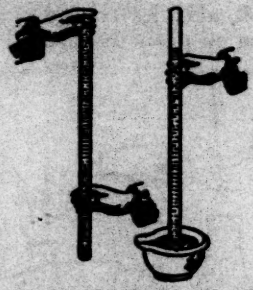
FIGURE 7.—THE ATMOSPHERE FORCES YOUR PALM INTO THE BOTTLE

It is the pressure of the atmosphere on the mercury in the open dish which supports the 30 inch column of mercury in the tube.

This experiment was made first by an Italian named Torricelli in 1643. It has been repeated thousands of times and it has been found that it makes no difference what may be the area of the mercury in the open dish, or the size of the tube, provided it is over 30 inches long. The height of the mercury in the tube, at sea level, is always about 30 inches, or 76 centimeters or 760 millimeters.

Atmospheric pressure per square inch.—Since the height of the mercury is the same no matter what the size of the tube, we may consider the inside cross section to be exactly 1 square inch (Figure 9). Then it is evident that the atmospheric pressure on 1 square inch at A is holding up a column of mercury B C containing 30 cubic inches of mercury. Now 1 cubic inch of mercury weighs .49 pounds; hence 30 cubic inches weighs .49 x 30 or 14.7 pounds. That is, the atmosphere

exerts a pressure of 14.7 pounds (nearly 15 pounds) on each square inch of everything on the earth's surface, at sea level.

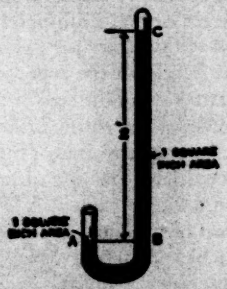


From Lynde, Carleton J., "Everyday Physics." By permission of The Macmillan Company, publishers

FIGURE 8.—TORRICELLI'S EXPERIMENT

Atmospheric pressure per square centimeter.—To calculate the pressure of the atmosphere per square centimeter, we may consider the tube (Figure 9) to have an inside cross section of exactly 1 square centimeter. Then the atmospheric pressure on 1 square centimeter at A holds up a column of mercury B C containing 76 cubic centimeters. Now 1 cubic centimeter of mercury weighs 13.6 grams; therefore, the pressure of the atmosphere on 1 square centimeter is 13.6 x 76 or 1033.6 grams.

The mercury barometer.—The barometer is an instrument used to foretell the weather. It is similar to the apparatus used by Torricelli. The pressure of the atmosphere on the mercury in the short



From Lynde, Carleton J., "Everyday Physics." By permission of The Macmillan Company, publishers

FIGURE 9.—MEASURING ATMOSPHERIC PRESSURE

open arm holds up the column of mercury in the long closed arm. The height of the column at sea level is about 30 inches, or 76 centimeters or 760 milli-

From Lynde, Carleton J., "Everyday Physics." By permission of The Macmillan Company, publishers

FIGURE 10.—THE MERCURY BAROMETER

meters, but it varies slightly from hour to hour because the pressure of the atmosphere varies. It has been found that if the mercury falls much below 30 inches, stormy weather is to be expected; and if the mercury rises much above it, we may look for fine and dry weather.

The water barometer.—Mercury weighs 13.6 times as much as water, volume for volume. Therefore, if we use water instead of mercury in a barometer we must use a very tall tube.

The atmosphere supports a column of mercury 30 inches (76 centimeters) high and it will support a column of *water* 13.6 x 30 inches or 408 inches (34 feet) high; in metric measure this is 1033.6 centimeters high.

There are various ways of stating 1 atmosphere pressure.

The Eight-hour Day

Its mass introduction in a large city hospital system

By MARY ELLEN MANLEY, R.N.

For years members of the administrative staffs of the New York City Department of Hospitals have considered the possibility of an eight-hour day for nurses in the public hospitals of New York. On March 11, 1937, a local law established the eight-hour day for all city hospital employees in New York City. On July 1, 1937, when the law went into effect, 650 of the 1,893 newly created positions were filled. (The remaining positions have since been filled.) The careful advance planning which made the change go smoothly is described.

THE EIGHT-HOUR DAY for nurses has long been heralded as inevitable. The moment of inauguration has been a matter of concern to those responsible for the care of patients because of apparent shortage of the necessary personnel and the imminent danger of the sacrifice of standards which have been the result of continuous, tedious effort on the part of those having high ideals of public service.

There are twenty-seven institutions in the New York City Department of Hospitals. The daily average number of patients in these hospitals is 17,200. Immediately prior to July 1, 1937, the working week for nurses employed in the Department of Hospitals, exclusive of those working forty-eight hours or less, ranged from forty-nine hours to sixty-six hours. Persistent efforts have been focused on the reduction of hours of workers in the Department of Hospitals over a period of years. Early in 1936 a survey of hours of duty and tentative formation of schedules for an eight-hour day were made. These formed a basis on which to build the plans for the eight-hour day when it emerged from the realm of fancy.

On March 11, 1937, a local law of New York City was amended to reduce the working hours of the employees in the municipal hospitals. This law became effective on July 1, 1937. The law applies to all workers in the Department of Hospitals, but the discussion here is limited to nurses and subsidiary workers.

The problem was how to enlist a large group of workers for a specific day in order that service to some 18,000 patients and guests in twenty-seven institutions might continue uninterruptedly. Nurses, subsidiary workers, and others had to be enrolled, oriented to new environments, given assignments, and supervised during performance of duties.

The Departmental Committee on the Eight-hour Day prefaced its preparations by visiting and conferring with executives of hospitals where the eight-hour day was in effect. The results of preliminary inquiry and planning fall roughly into four divisions, namely:

An estimate of the needs in personnel (nurses for patient care and supervision, subsidiary workers, and others); equipment (lockers and dressing facilities); services (food, laundry, health service, and medical care).

Preparation for installation (securing of personnel, preparation of persons in the institutions and preparation of newcomers, rearrangement of routines to shift peak load periods, reorganization of time schedules and assignment of duties).

Actual installation.

Treatment of problems evolving from the institution of the eight-hour day.

Several methods were considered in computing the needs of additional nursing personnel by a committee consisting of representatives from the offices of the Commissioner, the General Medical Superintendent, the Departmental Secretary, the Auditor, the Budget Director, and the Division of Nursing. A formula finally accepted by the Committee consisted of supplying the difference (in minutes) for each nurse between the potential work time of the nurse under the eight-hour day, and the potential work time of the nurse under the longer hours of duty, plus coverage.

The Committee was constantly aware that supplying actual minutes of service would not guarantee maintenance of existing standards of patient care. The Committee recognized that small units were less flexible and more costly than large; that in small units it is more difficult to arrange relief for meals, emergencies, et cetera.

A major problem faced during this preliminary period was the provision of workers for the preparation and service of the evening meal. It was impossible to arrange for the service of three meals within an eight-hour period. To meet this contingency, a part-time position was created for institutions located in vicinities where such help might be available. Duties were combined in full-time positions for institutions unable to secure part-time workers. In one institution, part-time positions were created for milk laboratory service.

Three weeks were devoted solely to the study of the unit needs by the Committee after much preliminary work had been done in the several institutions. As a result, 1,289 nurses, 349 attendants, 100 hospital helpers, and many miscellaneous positions, at an approximate cost of two and one-half million dollars were asked for and granted.

A survey of residence and laundry facilities revealed an inadequacy to meet needs of the increased personnel, hence all new positions were placed on a non-maintenance basis plus a laundry allowance. A locker was provided for each new position and the meal period was spread to allow three or more sittings as required.

Because it was not possible to secure a sufficient number of nurses having New York registration, it became necessary to modify the qualification requirements to permit the enrolment of nurses holding registration in the state where their schools of nursing are located. Letters were sent to all schools of nursing in the United States, to the presidents of alumnae associations of those schools, to every officer of all organizations listed in the official directory of the *American Journal of Nursing*, to colleges and organizations serving nurses. Many individual contacts were made. Approximately three hundred persons referred by the National Reemployment Service, New York State Employment Service, Works Progress Administration, and Emergency Relief Bureau were interviewed in the Division of Nursing office and referred to the institutions; advertisements were placed in professional magazines and in fifty of the largest circulating newspapers throughout the United States. Talks were given to professional groups. The greatest response was to the newspaper advertisements from which 1,500 replies were received.

Of paramount importance was the preparation of the staffs already in the hospitals for this innovation. Rearrangement of schedules, reassignment of duties, increased responsibilities of assisting new workers; in short, the responsibility for stabilizing the services during the change was theirs. This aspect of the program was facilitated by the spread of personnel over many units and the existing machinery of staff education.

Preparation of the new nurses embraced a scheme of concentrated orien-

tation programs and assignment to shifts of duty during periods when the maximum supervision was available. Arrangements for new nurses became effective after enrolment.

Sample schedules were circularized and material was interchanged in conference groups to facilitate the solution of common problems.

For the subsidiary worker, a plan was evolved whereby applicants for the positions might be assigned to the several institutions for an orientation period prior to July 1.

To prepare personnel in the individual institutions to effect this orientation of new workers, a four-day institute for the supervisors responsible for the subsidiary group was held under the auspices of the Division of Nursing.

On July 1, fifteen weeks after the eight-hour law for hospital employees was enacted, it became effective. A survey of the situation on that day revealed that all institutions were on an eight-hour basis, that the personnel was happy, and the patients ably cared for. Immediate problems were met through special adjustment.

The eight-hour day has been in effect in the Department of Hospitals for five months. Problems have arisen. For the most part, they have required only minor treatment.

On July 1, the existing vacancies on the regular hospital code plus the positions allowed on the eight-hour day created a total of 1,893 for which to find incumbents. Approximately 650 persons were enrolled on that day; the remaining positions have been gradually filled. On December 1, five months later, the vacancies existing on the staffs of the several hospitals are negligible. The turnover among the nurses employed as of July 1 has not been disproportionate with the turnover of the previous year. Some questioned the possibility of the success of the eight-hour day in the Municipal Hospitals, insofar as the availability of nurses was concerned. After this experience, can there be any question?

Maternal Mortality Declining

THERE HAS BEEN a continuous drop in maternal mortality in this country since 1929, and this drop is sure evidence that the campaign to safeguard the lives of mothers against the perils attending pregnancy and childbirth is finally bearing fruit. This campaign has been waged for nearly a quarter of a century, but it is only within the last few years that definite statistical evidence of its progress has become available. The decline has been considerable —about 17 per cent in six years. . . . .

In 1915 there were 61 deaths of mothers per 10,000 live births in the United States Birth Registration Area; in 1929 there were 70 such deaths; then followed the continuous drop to which we have just referred, culminating in 1935 in a maternal mortality rate of 58 per 10,000 live births—the lowest ever recorded in this country. . . . .

Medical standards have been raised both in private practice and in hospital procedure. Recent investigations have disclosed certain errors of commission and omission in the practice of obstetrics and these are gradually being corrected. Physicians and nurses are being intensively trained for better obstetrical service. The public has profited by the airing of the subject and has learned what type of care is needed for the pregnant woman, and to demand that such care be adequately supplied.

Again, through grants of Federal funds to backward states, better-trained personnel and more adequate facilities, such as prenatal clinics and efficiently supervised hospitals, have become available to an increasing proportion of the population of the United States. —*Statistical Bulletin*, Metropolitan Life Insurance Company, August 1937.

Approaches to the Psychiatric Patient

A study of methods

By DORIS RACINE JONES, R.N.; MARGUERITE L. KENNEDY, R.N.; AND ELOISE A. SHIELDS, R.N.

THE PURPOSES OF THIS STUDY of methods evolved from a number of factors. First, the writers wished to see whether or not it would be possible to state, in concrete terms, the expression of the somewhat intangible attitudes which may seem to be the intermingling of experience, tact, rapport, imagination, and many other qualities—terms concrete enough to give the student nurse, young and seeking experience in psychiatric nursing, a more conscious method of approach to the mental patient in order to secure that patient's acceptance of activities which in themselves may be considered organized living.

Most schools of nursing in psychiatric hospitals admit affiliated students from three to eight times yearly. From the point of view of the patient these changes must be made as danger proof as possible. From the student's point of view, the feeling of strangeness, almost of unreality, is deeply verified by the orientation program with its element of precaution against suicide.

Second, the actual application and conscious verbalization of methods of approach promised to give the experienced nurses working on the problems (even though no final category were obtained) a more critical, analytical attitude toward their own approaches.

Third, though no nursing technics might result which could be practiced almost routinely as is often possible in medical or surgical procedures, a classification of methods might result, which could be given as guides to students beginning their psychiatric affiliation.

The literature of nursing reveals little along these lines except generalizations built up on "don'ts," or on descriptions of the patient's reactions to what the nurse does or does not do. One psychiatric clinic offered concrete, objective help in the form of an admission sheet with specific guides to approach outlined for the nurse. It would seem very desirable, however, for the nurse to have at her conscious command all possible methods of approach and to use them all if necessary, rather than to rely specifically on the information gained by the physician during the admission procedure. Undoubtedly, though, these helpful suggestions serve to make the patient's admission care less difficult for him.

In an effort to formulate the methods discussed in the two studies here presented, three patients, regardless of diagnosis, who had proved to be difficult nursing problems, were carried through all activities for three days each. The detailed discussion of how each patient was induced to carry on such normal routines as personal hygiene, nutrition, treatments, occupation on the hall, and new activities, was formulated and reduced to nine methods.

These methods were then defined to emphasize the particular sense in which the terms were to be used in the study. The problems are first stated, then the procedure used in solution, and the results are recorded in more detail.

Statement of Problems

The first problem consisted in keeping detailed charts for five patients, recording which of the nine methods were used, and whether or not success or failure ensued in the use of these methods for twelve hours each day over a period of two weeks.

The second problem is a detailed study of one patient in an attempt to demonstrate some of the psychological problems involved in methods. The writers wish to state that they maintain no particular allegiance to any particular school of psychology, but have made use in a very general, obvious way of principles about which there is little controversy.

In this problem, as well as in the first one, many questions arose, such as: "Was the patient menstruating?" "Had her physician just visited her?" "Had she had visitors?" "What type of personality had the nurse who was caring for her during this activity?" There were also many others which could not be considered in the precision of detail or the scientific accuracy of a laboratory experiment. However, since the prime concern is with the affiliated student in psychiatric nursing, a general analysis of the average student's attitude had to be made.

Student Nurse Attitudes

The greatest problem confronting the new student in psychiatric nursing is the attitude which she should assume in her relationships with patients. The situation which she faces has a number of elements which differ from her past experiences in nursing. The ideas which she has formed concerning psychiatric patients may be, and frequently are, unsound.

Due to these erroneous conceptions (which are shared by the social group from which she comes), the student who experiences difficulty in her adaptation to psychiatric patients may be classified in one of several groups: those who are fearful and so adopt a firm, commanding attitude, as they usually explain, to hide their fear from the patients; those who feel that they are in a world of unreality and are unable to make an understanding, helpful approach; those who believe mental patients are "hopelessly insane" and therefore see little necessity for proper respect and serious attention to the needs of these patients; and those —especially those affiliating students whose primary contact is with patients of the convalescent group—who are unable to note the slightest sign of illness in behavior and consequently develop a critical attitude toward the hospital for keeping the patients.

The average student tends to be an outgoing, active, and sympathetic individual with a genuine liking for people. She has a fairly even disposition and is self-controlled. In resourcefulness, she is somewhat above the average girl of her age. Her physical health is good and her aptitude for arts and crafts, as well as her motor ability, vary considerably. A change in attitude from the one she has developed in general nursing to one more adapted to psychiatric nursing is necessary.

In the general hospital she has played a more aggressive rôle in the nurse-patient relationship. In most instances rapport with her patients has developed naturally. She has been accepted by patients without question and there has not been a constant demand on the emotional side of her personality. The reaction of the nurse to the patient and vice versa has not called for the very serious consideration it must have here.

In the psychiatric hospital, she enters a situation where she is to be an aide in approaching a goal which the patient is often resistant to approaching. The right of the student to enter the situation at all is seriously challenged by the mentally

ill patient. She is part of the situation—hospitalization in a mental hospital—which he cannot accept easily. She must develop an objective, passive, and more neutral attitude. Her approach must be flexible to meet the needs of individual patients. At the same time, she is in an environment with many irritating stimuli. The importance of explanations and frequent reassurances should be uppermost in her mind. It is essential that she develop her powers of observation to the extent of being able to watch a patient closely without appearing suspicious or obtrusive.

Rapport with patients cannot be gained instantly. Most frequently it develops through three stages: (1) the stage of friendly belief, in which the nurse shows interest in the patient's welfare, but during which confidence on the patient's part is not forthcoming; (2) the stage of personal trust in which the patient is more suggestible than in the first stage; (3) the stage of personal contact, a deeper stage of personal trust in which the patient likes the nurse and is anxious to be understood by her. All these depend on the nurse's ability to be alive to and to take cognizance of all the implications of the patient's needs without allowing her own emotional reactions to warp her judgment.

By placing emphasis on these points in the orientation period, the student's attitude from her first contacts with psychiatric patients may be made more helpful to the patients and more satisfying to her. She will gain a new concept of mental illnesses, a new interest in nursing all illnesses because of the better understanding of the importance of the mental as well as the physical comfort of her patients. She should also, during her student experience, develop a toleration for the feelings and aspirations of others and a better understanding of her own personality and reactions. She should complete her affiliation with an increased adaptive ability and a strengthened philosophy that will give her more security, self-respect and strength of purpose.

The First Problem

Selection and definition of methods.—After a very careful checking of the records, behavior, and daily routine of twenty patients, five were selected for the first problem and one for the second problem, for a number of reasons:

1. For a long period, these patients had been complicated, difficult nursing problems, but it was felt by the writers that more could be done with them if sufficient time were given them.
2. In past experience, the two factors of time and persistence had been helpful with patients who showed similar resistance to all routines.
3. When these six patients were given concentrated nursing attention, their reactions were less severe than the reactions of other members of the patient group under the same circumstances. The comfort of the entire department had to be considered.
4. These patients were having treatments which afforded greater opportunity to have close contact with them.
5. These patients were a challenge because they had accepted only limited routines up to the time of the study.
6. One patient, though not newly admitted to the hospital was new to this service.

It is important to note here that diagnosis was not a factor in choosing these patients. The most heavily weighted factor was behavior. However, the diagnoses of the six patients studied in the two problems included three dementia praecox patients, one paranoid and two hebephrenic type; two involutional psychoses, melancholia type; and one manic depressive, depressed type. All these patients, but one, had been ill for a number of years.

The methods selected (that is formulated by discussion of actual nursing practice on three patients for a three-day period) were defined and examples of each selected from actual nursing practice. These are:

1. *Suggestion:* Presenting to the patient in a casual manner an idea which he accepts in

the absence of any expressed logical grounds for acceptance.
Example: "Your bath is ready."

2. *Persuasion:* Giving the patient what he considers logical grounds for the acceptance of the idea presented to him.
Example: "Your bath is ready. If you have it now, you will be relaxed and prepared for a good night's rest."
3. *Unconcern or simulated indifference:* Presenting an idea with no feeling for or against it expressed by the nurse.
Example: Mrs. H. objected to being asked to do anything, so the nurse laid out her clothes for her, and without any remarks or suggestions left her alone. Patient dressed herself in due time.
4. *Indirection:* The act of working in a roundabout way by means of a third person.
Example: One nurse conversed with another within the hearing of the patient: "If Mrs. H. finishes her lunch by two o'clock, she will be able to go out walking with her husband."
5. *Stimulation followed by isolation:* Setting a goal for the patient, leaving him alone to act.
Example: The nurse set a breakfast tray in front of the patient, saying, "You should start eating because it will soon be time to go to the gymnasium." The nurse then left the room.
6. *Compensation:* Making a suggestion to the patient which derives its value not so much from the magnitude of the service or return as the intentions of the persons toward each other. (NOTE: This term is *not* used in the usual psychiatric sense.)
Example: If you follow your morning routine, we will be able to visit the library this afternoon where you may look for the book you've been asking for.
7. *Implication:* Instilling a sense of responsibility in the patient for his own reactions.
Example: In answer to a patient's request to be moved to another hall the nurse replied, "You know on that hall they have a very active daily schedule. If you will eat more, take your nourishments between meals, and gain some weight, you will be able to carry out such a program. Perhaps then your doctor will consider moving you."
8. *Distraction:* Using a dramatic quality—unexpectedly fulfilling a request which the patient has made repeatedly. The request may seem irrational, but the granting may give some feeling of confidence to the patient.
Example: Patient who thought her mother was being tortured on the floor below talked constantly about it. She asked frequently to telephone and send aid to her mother. This request, made hundreds of times a month, was occasionally granted somewhat to the patient's surprise. After, a brief conversation by telephone with the head nurse on the floor below, the patient appeared reassured for a period.
9. *Compulsion:* Applying force, either on mind or body to influence conduct.
Example: Patient refused day after day to go out on the grounds. Every method of approach was used and each failed. Patient was finally assisted to the door and carried down the steps to the grounds.

The nursing problem.—Charts (see page 32) were made for each of the five patients with headings to include all the daily routines. These charts were kept continuously for a two-weeks period. The methods were numbered from one to nine in the order in which they were defined, and the actual practice with patients and the charting were done by the nurses who helped formulate the methods. One chart and a discussion of methods on one patient only is included here. Both refer to the same patient.

The patient's behavior and personality.—Before her illness the patient, Miss A. A. was of slow, average intelligence; inclined to be overconscientious, suspicious, reticent, easily distracted, and to pay a great deal of attention to unexpected stimuli. She had little self-reliance, was dependent on family, and seemed to have a marked feeling of inferiority. Her emotional responses seemed adequate to her expressed thoughts, but she was inclined to procrastinate and waste time in putting her thoughts into action. Tactlessness, mild enthusiasms, absent-mindedness, and narrow interests coupled with a self-centered, stubborn, fault-finding, though kind-hearted, attitude caused her to appear dissatisfied with life and made her wish to leave the family circle. She had always been quite religious.

During her present illness, she is alternately lethargic and overactive. She will

METHODS OF APPROACH TO PSYCHIATRIC PATIENTS

Patient: Miss A. A.
Ward: Semi-disturbed
Admitted: Nov. 29, 1935
Diagnosis: Hebephrenic dementia praecox
Age: Twenty

Key to methods of approach:
1. Suggestion
2. Persuasion
3. Unconcern
4. Indirection
5. Stimulation and Isolation
6. Compensation
7. Implication
8. Distraction
9. Compulsion

"F" indicates failure; "S" indicates success.

CHART OF ROUTINES OF AVERAGE PATIENT'S DAY, 7.00 A.M. TO 7.00 P.M.

Date	Personal Hygiene				Nutrition					Treatments				Occupation		New Activities	Remarks
Feb.	Bath	Teeth	Hair	Dress	Bkf.	A.M.	Dnr.	P.M.	Spr.	Med.	Pack	P. B.	Enemata	Hall	Self		
Wed. 12	1 F 2 S	2 S	1 S	1 S	1 F 2 S	1 F 2 S	1 S	1, 2, 3 F, 9 S	1, 2 S	1 F 2 S	1 F 2 S	1 F 9 S	1 S		1, 2 F 3 S		Bkf. spoonfed in pack. Ate dnr. alone.
Thur. 13	1, 2 F 9 S	2 S	9 S	1 F 2, 5, 9 S	2 S	2, 5 F	1, 2 F	9 F	1 S	2 S	1 S	1 S			1 F 2 S	Singing class 1 F, 2 S	Spoonfed. Regurgitated A.M. nourishment. Ate spr. alone.
Fri. 14	1, 2, 3 F	1 S	1 F 2 S	1 F 2 S	1 F 2 S	All F	1, 2, 5 F	1, 2, 3, 5 F	1, 2, F	1 S	2 S	1 S			1, 2, 5 F		Spoonfed bkf. Tubefed dnr. spr. Med. in feeding.
Sat. 15	1 F 2 S	1 S	9 S	1, 2 F 9 S	1, 2, 9 F	F	F	F	F	9 S	2 S	omit			F	Read magazines 1, 2 S	All meals and med. tubefed. Mother visited.
Sun. 16	1 S	1 S	1, 2 F 9 S	1 F 9 S	F	F Tube fed	F	F	F	F	2 S	omit	2 S		F	Shampoo 1 F, 9 S	Refused all meals, fluids. Tubefed twice.
Mon. 17	1 F 2 S	1 S	1 S	1, 2 F 5 S	F	F Tube fed	F	F	F	2 S	2 S	1 F 2 S			F		Tubefed all meals.
Tues. 18	1 S	1 S	1 F 2 S	1 S	F	F Tube fed	F	F	F	F	2 S	2 S 1 F			F		Tubefed all meals.
Wed. 19	1 F 2 S	1 S	1 F 2 S	9 S	F	F Tube fed	F	1 F 2 S	F	F	2 S	2 S	2 S		F		Tubefed all meals.
Thur. 20	1 S	1 S	1 F 2 S	1, 2 F 9 S	1, 2 F	F	F	2 S	1, 2, 5 F, 9 S	F	2 S	1 S			F	Walked to Occ. Bldg. 2 S	Tubefed bkf.
Fri. 21	1 S	1 S	1 F 2 S	1 F 5 S	1 F 2, 9 S	2 S	9 S	F	1 F 2 S	F	2 S	1 S			F		Spoonfed.
Sat. 22	1 S	1 S	1, 2 F 9 S	1 S	1 F 2, 9 S	2, 9 F	2 S	F	1 F 2 S	F	4 S	1 F 2 S	1 S		1 F 2 S	Read newspaper 1, 3 S	Spoonfed
Sun. 23	1 S	1 S	1 F 2 S	1 S	1 F 2, 9 S	1 S	1, 2 F	F	1 F 2 S	F	1 S	omit			1 F 2 S	Visited on other wards 1, 2 S	Spoonfed. Family present at noon. Refused to eat.
Mon. 24	1 S	1 S	1 S	1 S	1 S	1 S	1 S	1 S	1 F 2 S	1 S T.i.D.	1 S	4 S			5 S	Reading paper 2 S	Spoonfed. Ate well. Alert.
Tues. 25	1 F 2 S	1 S	1 S	1 F 2 S	1 S	1 S	1 S	1 S	2 S	1 S T.i.D.	1 S	1 F 2 S			1 S		

suddenly fall to the floor, become limp, appear unconscious for short periods. Again she will dash down the hall calling, "Let me out of here," or kneel suddenly at any place on the ward to pray. Her behavior during the greater part of each day is resistive, negativistic, suspicious, and apprehensive. Occasionally impulsive, she strikes at the nurses. She also shows evidence of auditory hallucinations, says her mother is being detained downstairs, and she calls to and answers her mother and a girl friend.

The methods used.—The chart opposite gives a picture of two weeks' work with this patient. However, a little discussion will help to clarify the chart.

Personal hygiene: The patient usually accepted her cleansing bath when it was *suggested*. Several times she had to be *persuaded* and once she was *compelled* to take it. She brushed her teeth every day at the time it was *suggested* except twice when *persuasion* was successful after *suggestion* failed. She usually combed her hair after she was *persuaded* to do so. Twice it was necessary for the nurse to do it for her. For five days she dressed herself at the *suggestion* of dressing. Two days she refused to dress and was *compelled* to permit the nurses to dress her. On the second, sixth and tenth days of the study, *stimulation and isolation* were successful.

Nutrition: For six and one-half days she refused to take any food by mouth so that it was necessary to tubefeed her. For another like period, she allowed the nurse to spoonfeed her but only after much *persuasion*. *Suggestion* was effectual the last two days except for one meal.

Treatments: Her medication, Lugol's solution, was given in tubefeedings. No method but *compulsion*—in this case tubefeeding by the physician—was tried for eight days. *Persuasion* or *suggestion* succeeded on the others. She accepted her packs following *suggestion* for four days. *Indirection* for one day, and the remaining nine days she was *persuaded* to accept them. Prolonged baths (abbreviated P. B. on chart) were accepted at *suggestion* for four days; for five days she took them after much *persuasion;* one day *indirection* was used with success. Four enemata were given in this period. Two she accepted after *persuasion*, two following *suggestion*.

Occupation: For seven days she refused to engage in any activity on the hall. For three days she was finally *persuaded* to do some sewing, one day *unconcern* was effective, and for one day *stimulation* followed by *isolation* was successful. On the last day of the study she sewed when it was *suggested*. At no time was she induced to engage in occupations on the hall which would have been of value to other members of the group.

New activities: These are called "new" because she had been unable to engage in them during her illness. *Suggestion, persuasion,* and *unconcern* were successful, at various times, in getting her to read the newspaper. Once she read magazines, brought by her mother, following much *persuasion*. It was *suggested* and she accepted, that she visit on more comfortable wards with a nurse. She was once *persuaded* to walk to the occupation building, but she refused to go in.

In brief summary, therefore, it would seem that in the case of Miss A. A., Methods 1 and 2 were most frequently effective; 3, 4, and 5 were occasionally successful; and Method 9 was used more often than in any of the other cases. This was necessary, however, because the patient's physical condition made it imperative that all feedings and medications be given on schedule. In one of the other cases, a very involved dementia praecox, paranoid type, Method 8 was used effectively as a reassuring measure. Methods 6 and 7 were used often enough in the other cases to warrant their inclusion in the classification.

One observation, however, made many times by the nurses who were analyzing and recording these methods, was that if there were enough time available, most patients could be helped toward accomplishing the greater share of the normal routines of daily living. A controversial point here is, of course, best expressed by an illustration: Is it really a normal routine if a patient with constant nursing care can be induced to eat a meal though she take three hours for the process? There seems to be no exact answer, but it seems evident that enough time to devote to the individual patient is a factor not to be overlooked.

The Second Problem

The second problem of approach was an attempt to outline if possible and then definitely to use the generally accepted psychological principles which attended the detailed efforts to induce a retarded, negativistic, suspicious, careless patient with an extremely short attention span, to engage in a purposeful activity covering in its related stages about three days.

The patient's behavior and personality.—Mrs. D., previous to her illness, is described as a person of limited intellectual attainment, dependent, absent-minded, affectionate, seclusive, having very narrow interests and suffering from a sense of inferiority.

A careful study of the history was made to find anything in which Mrs. D. was moderately interested. She had been on a semi-disturbed service for many months and had engaged only in the simplest activities for very short periods. She always dressed herself hurriedly, carelessly, and not always completely; she ate rapidly, untidily and ravenously. Her most complex accomplishment was simple knitting done automatically with many errors. Her record revealed that she had a mild interest in cooking and a great interest in golf. The weather precluded golf from the problem. A factor of importance, in working on the problem, was the patient's feeling of inferiority. Just previous to the acute onset of her illness, she had developed an increased feeling of social inferiority to her husband who had made wealthy friends and left her rather more alone than usual.

The project, therefore, needed to be one which would include cooking and would stimulate, if possible, a feeling of social security. A plan was formed to induce Mrs. D., who had done little but poor knitting, to bake a cake in the occupation department, dress herself becomingly, and serve tea to a group of patients on the ward. It was decided to have her serve the tea, as an added stimulus, on the afternoon that the musical director visited the hall.

The psychological principles on which this problem was planned were as follows: Organized efforts on the part of the nurses were necessary to gain and hold the patient's attention through intensive and extensive stimuli and through repetition of information concerning the project.

Next, interest had to be created through stating the importance of the activity in terms of the new as related to the old—that is baking, the older reaction, but in the occupation department which was a rather new idea for the patient. In fact, the patient connected cooking rather slowly, doubtfully, and a bit suspiciously with the other activities in this department.

Desire had to be aroused, if possible, through attention to and creation of images, attended by pleasurable emotion, and leading to activity toward the object. Mrs. D. had a ravenous appetite though she did not seem to show discriminating ideas on the subject of foods. However, this stimulus was readily acceptable and helped lead her towards the goal.

Confidence, the next step was not so easily aroused, as Mrs. D. was quite suspicious of those about her and her own insecurity was always evident in both behavior and conversation. Many and repeatedly persistent efforts were made to create confidence by repetition to give her the idea of the satisfaction such a project would give the entire patient-group, her husband when he heard of it, and the pleasure she, herself, would experience. Satisfaction, or the ultimate goal, had to be presented very indirectly, but it had to be the fulfilment of a real need felt by the patient. The tea party itself, with Mrs. D. as the important, focussing point of the guests' attention was the goal as a step on the road, per-

haps, to a greater feeling of social security with her husband.

Methods used.—Two days preparation of the patient preceded the culminating activity. On the first day she was given a cookbook to look at. This was a very attractively illustrated and recently published one. She glanced through it briefly and returned it, remarking, "Yes, it's nice—I can cook many things without a book. I used to cook quite a lot." Then she wandered down the hall repeating, "Why did I ever come here? I want to go home."

On the second day, the nurse persuaded the patient to sit with her while knitting and the following conversation took place:

NURSE, "You said you knew how to cook, didn't you?"

MRS. D., showing some interest, "Yes."

NURSE, "Do you know how to bake cakes?"

MRS. D., "Yes, I used to like to bake cakes, my son liked them."

NURSE, "What kind of cake do you enjoy making most?"

MRS. D., "Chocolate."

NURSE, "That's fine. Why don't you make one in the occupation department? There is a kitchen with all the necessary articles."

MRS. D., walking away, "I can't bake one now." Then, hesitantly, "If I baked one now—I want to go home."

NURSE, "We haven't had a party in some time. If you would bake a cake for us, we could have a very nice party."

MRS. D., returning apparently interested, "I always use my own recipe. I don't need a book to go by."

NURSE, "Splendid. We'll plan a party. You bake a cake, we'll have tea, dress up, and invite a few extra guests."

MRS. D., "Will it be all right? I don't know, maybe I shouldn't."

NURSE, "It will be quite all right. You think about it and we'll surprise the others."

MRS. D., "Well, I don't know." She was very uncertain and inclined to be suspicious about the whole matter.

Arrangements were made with the occupation instructor for nine o'clock the following morning. The nurse approaching the patient who was aimlessly pacing up and down the hall.

NURSE, "Will you go with me to the occupation building to return this cake pan?"

MRS. D., walking away, "Oh, no."

NURSE, "You aren't busy and you'll enjoy the walk."

MRS. D., "Oh, well, what's the use." However, she powdered her nose, at the nurse's suggestion, and followed her hesitantly to the building.

NURSE, on the way over, "Wouldn't you like to bake a cake in this pan?"

MRS. D., "Oh no, I wouldn't. It couldn't be right. No, I'm not going to bake a cake." There was, however, a note of uncertainty in her voice.

NURSE, on arriving at the building, "I wonder if anyone is using the kitchen today?"

MRS. D., "I don't know." She then walked down to the kitchen, found the door open and entered.

NURSE, "Mrs. D., it looks as though you might be able to bake a cake now."

MRS. D., "Yes, it does."

NURSE, "Do you want a cookbook?"

MRS. D., "No—yes. Well, I guess I remember how to make a chocolate cake." She appeared interested and inspected the utensils, taking a few from the shelves.

NURSE, "I don't think Miss H. (occupational instructor) would mind if you baked your cake now."

MRS. D., "Would you mind? But then I know I shouldn't. I think something is going to happen." Meanwhile she gathered the ingredients and began mixing. She seemed quite pleased, joked rather apologetically, worked rapidly though in a rather careless manner, and remained in the kitchen until the cake was finished. It took a good deal of persuasion to induce her to carry the cake back to the hall.

With much persuasion, in the afternoon, the patient assisted with arrangements for tea. She walked aimlessly about the table occasionally placing some of the tea service, but protesting, "I shouldn't do this. I had no idea I'd have to do all this."

At the suggestion of the nurse, she put on a new dress, powdered her face, and arranged her hair. When told that it was time to serve tea, she went willingly to the dining-room and took the place behind the tea service without hesitation. She poured tea for everyone and, quite out of keeping with her usual behavior, waited for others to be served before

helping herself. Then, in spite of her ravenous appetite, she ate only a moderate amount rather carefully. She remarked to the nurse, "I wish I had made two cakes and I should have taken more pains with this one." Mrs. D. seemed unusually pleased when several of the physicians and supervisors dropped in for tea and cake. At the close of the tea, with no assistance from the nurse, she accepted the thanks of the guests in a very normal, responsive fashion.

This problem (not given in as full detail as it was developed but in enough detail to illustrate the approaches) may read like a rather simple little story, but in carrying the project through it was possible for each member of the nursing personnel on the service to try out many of the methods discussed earlier in the paper. Careful judgment had to be exercised at each step in order to stimulate the patient to activity, commensurate at all times with her ability as limited by her illness, and to do so without antagonizing or discouraging her.

In conclusion, no hard and fast lines concerning methods and their uses can be drawn, but the purposes stated earlier have been realized. First, a category of methods has been formulated although, with actual practice, it will undoubtedly undergo changes. The second purpose—to give the nurses working with the problem a more analytical attitude toward their own approaches—has also been fulfilled. Finally, it would seem possible to teach these methods to incoming affiliated students through class discussion, by having the student observe them in use on the wards with attention drawn to specific approaches, by allowing her to experience the conscious use of them in working with the patients, and by assisting her to develop a critical attitude toward the success or failure of her own use of these methods.

Bibliography

Case records and charts of six patients.

Crabb, George: *Crabb's English Synonymes.* Harper, 1917.

Kitson, H. D.: *The Mind of the Buyer.* Macmillan, 1921.

Roget, Peter Mark: *Thesaurus of English Words and Phrases.* Grosset, 1933.

Strecker, Edward A., and Appel, Kenneth E.: *Discovering Ourselves.* Macmillan, 1931.

White, Wendell: *The Psychology of Dealing with People.* Macmillan, 1936.

How Men Get Hurt

"The average man engaged in an occupation not involving any special hazard is, nevertheless, exposed to the common everyday risks of injury. Actually, more business men get hurt in office buildings and stores than while riding in automobiles; and more of them come to grief in and about the house than when walking on the streets or using trains and other public transportation services. . . . .

"Accidents in automobiles accounted for 20 per cent of the total (of 104,000 accidents to Metropolitan Life Insurance Company policy-holders). . . . . In another 8 per cent of the cases, the victim was injured while walking on streets; only 2 per cent of the accidents occurred on transportation services. . . . . Nearly 13 per cent of the aggregate number (of accidental injuries), were received while bathing, bowling, riding horseback, playing baseball, tennis, golf, and other games. . . . . The largest number of accidents in this group were described as falls on sidewalk, pavement, or uneven ground. . . . . No less than 636 men were hurt by falling in tubs or shower stalls. . . . .

"It is a good plan to make an occasional survey and inspect the home or office for avoidable hazards, such as loose rugs, inadequate lighting, obstacles on stairways, et cetera. . . . . Seemingly trivial and minor mishaps frequently result in serious injuries with consequent loss of time and income." *Statistical Bulletin,* Metropolitan Life Insurance Company, September 1937.

The Play Teacher

Who keeps children profitably and enjoyably busy

By ETHEL SYKES, R.N.

WE ALL UNDERSTAND by now that any experience undergone has its effect upon the individual. Those of us who are concerned with the care of children through a hospital stay have an obligation to control conditions so that the effects shall be as favorable as possible. Every contact of every nurse in every situation involving children bristles with learning possibilities. Meal time, visiting time, rest time, bath time, treatment time and play time, all offer opportunities to the alert and prepared nurse to further desirable attitudes and behaviors. This educational aspect has in the past been neglected, and I am sure that none of us in pediatrics today is satisfied with the present extent of our efforts along this line. We are only beginning to use the opportunities implicit in our work. There are difficulties in the way of their full realization, but our first need is for an awareness of them. Progressive education, with its development of the nursery school, and its reconstruction of educational method, has much of pertinence to suggest to us.

It must, of course, be understood that in pulling out this phase of child care for discussion, we are not in any way losing sight of the fact that our first obligation is the skilled physical care of sick children. Nevertheless, it is true that we cannot give skilled care without understanding children as well as disease and it is further true that at our best we should be competent to give intelligent educational guidance along with such care. We believe that this is a goal to work towards, and it raises many questions as to whether it is really possible of achievement with the present assignment of students for three or, at most, four months to the pediatric service. Still, we can make a beginning, and many schools are already doing much towards the goal.

There follows a discussion of the activity program as it is being developed at the New York Hospital, which we consider an important part of the educational care of children. Through it we try to keep our small patients well-minded. It is out of the needs of children that we perceive the needs of student nurses and upon them that we build our teaching content and method.

WHAT IS PLAY?

Many of us still think loosely of play as entertainment, or a sort of pleasant spending of one's time on nothing much at all. We smile tolerantly as we watch children at play, finding it "cute" or amusing, but secretly dismissing it as having very little to do with the sterner things of life. Current educational practice attaches a very different significance to the play of children, recognizing that while he plays the child is learning many things. He is acquiring facts about his physical world, he is learning to manage his body and coördinate his movements, to meet problems, and to express his ideas. He is building attitudes and when his play involves others he is learning social values. The sorts of learnings that a child comes through with depend upon many factors: upon his constitutional endowments, his maturing faculties, his materials, and his social environment, particularly the guidance of the adult.

Towlin and MacKean, Courtesy Harmon Foundation

During Her Two Weeks as "Play Teacher," the Student Is Relieved of Routine Patient Care

The two-year-old who cries lustily until help arrives when the string of her pull toy gets caught about the table leg, has learned something; the small boy who puts one block on top of another to reach what is wanted, has learned something. A thoughtful observance of any child's play will reveal learnings in process. So when as nurses we concern ourselves with the play experiences of our patients we need to know something of this significance and it is no small part of the student's orientation to acquire such understanding. We have used the term activity as being more inclusive than that of play, but we are not attempting to draw the line between the two. By activity we mean being profitably and enjoyably busy.

The Raw Materials of Play

An activity program calls for materials, and perhaps for many of us this need presents a problem. In our situation we do not have the range that we would like to have, nor do we as yet have a regular income for replacements and additions. As it is, however, there are ways of raising funds, and it is surprising what the community will yield if its resources are tapped. There are many odds and ends that can be passed on to pediatrics: ribbons and laces, silks and cottons, yarns and buttons, pictures and magazines that would otherwise find their way to the waste basket.

"General Stores" overflows with usable boxes on supply day, and a great many good things come from the carpentry shop. Left-over bits of lumber serve as building blocks. The children count it a great event to go to the shop and help collect and bring "home" the blocks to be sandpapered down. They take great pride in getting rid of all rough surfaces so that small fingers will not suffer splinters. Sometimes we have a wave of enthusiasm for colored blocks

Paul Parker Photo

THE CHILDREN AT THE NEW YORK HOSPITAL CALL THE STUDENT TEACHER, THE "PLAY NURSE"

and go journeying to the paint shop to see what we may have. Our chief carpenter has made many useful things for us: a painting easel, a sandbox, a toy carrier, a blackboard, storage shelves, a book carrier, and some puzzles.

We have bought poster paints and painting brushes, a tub of modeling clay, a few weaving frames, knitting needles and spools, scissors and paste, dolls and animals, tea sets, beads, wrist bells, games, and puzzles. We have a few manipulative toys for the younger children, some growing plants, a canary, and a pair of turtles. We have inherited an electric train, a tricycle and a kiddy-car.

Last Christmas an adult patient, hearing of our enterprises, made us a gift of a good victrola. We are building a library of records, including quiet, relaxing melodies as well as some more lively ones. We have consulted the list of suggested recordings for young children put out by Educational Playthings, Inc., in consultation with the primary department of Teachers College. We have had some very interesting times with music; it is always much enjoyed by the children and they take great pleasure in choosing what shall be played. One little boy was very quick to recognize sacred music and at the first bar he would say "That's a God song, isn't it?"

Then, our further resource is a library. The books have been selected with care to meet all age and taste preferences. There are big books and little books, pictured and unpictured, fanciful and realistic, romantic and adventurous, informational and nonsensical. These, then, are our "raw materials," and familiarity with them and with their use is essential to the student's success.

THE PROGRAM FOR STUDENTS

While students are having their experience in the pediatric service they are attending classes in child development

and psychology. Through group conferences this helpful theoretical background is correlated with their practice. The students' backgrounds vary, however, in the amount of experience had with children in the home or community, and in individual childhood backgrounds. These factors are quite important.

Some come to the work with keen zest and are very close in spirit to the enjoyments of children; others find it difficult to identify themselves with the children's interests. Some have never modeled in clay, others have fingers that itch to be at it again; some have never known Little Black Sambo, others chuckle reminiscently at mention of his name. The students who have rich childhood experiences to draw upon are generally more successful in guiding the activities of the children. Being at ease with the materials they are able to concentrate on developing their technics of guidance. If time could be arranged, it would be profitable to have students get together for informal evenings of games, reading, story-telling, painting, and modeling.

For two weeks the student serves as "play teacher" (the children have spontaneously taken up the term "play nurse," so perhaps that is the name that will survive) during which time she is relieved of routine patient care. If we are able to have two students, the first week is spent caring for the activities of the convalescent or chronically ill patients who are able to be taken to the solarium or roof garden after their morning care is completed. They may be "up and about," in wheel chairs, or in beds. Ages range from two to twelve, and numbers up to about fourteen.

Before beginning this experience the student by individual conference is given some idea of the importance and purpose of the work and some conception of her function. When offering activities she must constantly have in mind the child's physical condition, remembering that he must not be fatigued or overstimulated and that his position will have bearing upon the sorts of things that he can do. The student needs to know something of age-level interests, capacities, and attention span, and she must ever be alert to individual differences.

It is important that children get satisfaction out of their activities, so that the adult must be mindful of the need for directing technics so that whatever is undertaken may be brought through to successful completion. Misguided work may be harmful to the child's personality growth. The instructor guides the student in practice to help her to take all these values into account. Sometimes we find a tendency to "play with" the attractive or amusing child at the expense of the quiet, less outgoing one. To learn when to step in, and when to stay watchfully outside requires much experience and understanding. Some students are much more sensitive than others to the significance of their contacts with children at play. We try to encourage independence, give and take, and a real "busy-ness." We attempt to follow a somewhat routinized day, having times for active play and quiet times for story and music. By balancing rest and activity we avoid fatigue.

The second week is spent as play teacher at the bedside. Each morning the toy carrier is set up and taken round so that the children can make their selections. Help is given where needed. Books are also taken round daily and there is usually eager anticipation of their arrival. To be able to offer the right book to the right child at the right time is a far-reaching contribution to the education of the child, and we like to think that many children who have sojourned with us have gone home with pleasant literary recollections. It has sometimes happened that at a second admission a child will ask if we still have such and such a book because he would like to read it again.

To learn how to distribute her time wisely is an important part of this bedside activity for the student. Time pressure prevents us from doing all that we would like, so that discrimination is very necessary. The child who has chorea and is unable to depend upon himself for activity must have some part of the day when he can look forward to something pleasant—a well-chosen story or recording.

During this assignment as play teacher the student is participating in a series of informal class discussions on related topics. In connection with these she is expected to make simple records of observed behaviors and to analyze them. The ability to observe accurately and pertinently is essential to an understanding of children. Children at play in the park or on the street offer much instruction to the alert; we often use such observations in our class discussions.

Making Toys

While on the children's service the student makes a toy or some piece of play equipment. On the assigned day we assemble to examine and discuss each contribution. There is an air of mystery on the morning of the exhibit. Strange bumpy packages appear from nowhere and the conference room takes on a festive colorfulness. Each student presents her toy and makes a verbal report as to its cost (the less the better), the source of the materials, its play value and age suitability, and the method of making. It is passed round for examination and all are free to offer comments. I am sure that we have learned a great deal from these exchanges.

We have had some really splendid contributions into which have gone much originality, resourcefulness, and knowledge of children. A puppet show of the "Three Bears," a set of farm animals with a strong roomy barn, and a child-size store are among our most notable achievements. For such ambitious undertakings the students have worked in pairs, and where much woodwork was involved they had the help of the carpenter. Smaller toys of very real merit have been made at negligible cost and have proved their acceptibility to the children.

The students may make what disposition they wish of the things they have made, but most of them find their way to the children's floor either as individual gifts or as additions to the common stock. Seeing their toys in action has great learning value to the students; they see the fate of the poorly constructed toy, the neglect of the unsuitable, and the continued usefulness of the well-made and well-selected.

Making Environment Count

We also count it important that the students be able to meet the children's interests in their surroundings. We are most happily situated on the East River, with its teeming traffic, its whistles and lights and bridges. The children are endlessly interested in it, and full of questions. We often find ourselves humiliated that we should know so little about it. Students have elected to explore some phase of river interest, such as ferry boats, barges, bridges, traffic regulations, et cetera, and have brought back their information to share with others. The river interest is reflected in the children's play; they build docks and ply imaginary steamers down imaginary waterways. We often have quiet play when we listen for certain sounds from the river; the "El" going over the Queensborough Bridge, or the warning whistle of an overtaking boat.

Then there are the sources of interest in the hospital itself. A ride in the elevator on the way to x-ray raises all sorts of questions. The "up-and-about" children enjoy and profit from an expedition to the main kitchen or the storeroom or

the carpentry shop. We like them to know the hospital as a community where all sorts of interesting activities are going on and where workers of every kind contribute to the general upkeep. Such learnings have real social value and children are much more likely to come through with wholesome attitudes if the hospital stay has been enriched by excursions of this sort. Of course, safeguards in the matter of exposure must be observed, but with judgment danger can be eliminated.

Low-cost Toy and Book Exhibit

Before closing, I should like to mention the exhibit of low-cost toys and books that we are now working on. The instructor and two students spent a Saturday afternoon buying at the "Five and Ten." This was an exercise in discrimination and was a very profitable experience all the way around. Selections were made on the basis of suitability for hospital use, size, durability, safety, age-range interest, and educational value. Of all the toy motor cars on display, which should we buy and why? We finished with an impressive array of really worth-while things, most of which had cost ten cents, a few five cents, and still fewer twenty-five cents.

The selection of books was equally exacting. We were well pleased with the number of excellent books offered at ten cents, though of course there were an equal number of less admirable ones. The work of The Artists and Writers Guild in sponsoring the production of worth-while low-cost books is a splendid one and worthy the support of everyone interested in literature for children.

This exhibit is to be used for parent teaching. The plan is not yet in use, but we hope to make it part of the student's experience to show the materials to visiting parents. The number of valueless toys that find their way to the children on visiting day bears eloquent testimony to the need for this sort of help. Which brings us back to the point we made in the beginning; there is much to be done.

Safe Drinking Facilities

Contact infection from one individual to another is the means of spreading a great deal of sickness. Frequently the contact is brought about through such intermediaries as the common drinking cup or insanitary drinking fountain. State sanitary codes prohibit the use of common drinking cups in public places. . . . . Definite standards for construction and installation of sanitary drinking fountains are available. Yet drinking fountains are frequently found so poorly constructed as to be actually insanitary.

Standards for sanitary fountains provide a type of equipment that can be kept clean; protected jets where the mouths of users cannot come in contact with any part of the fountain; slanting jets for conveyance of waste water as it leaves the mouth so that it does not contaminate the fixture; and jets located above fixture rims so as to avoid pollution from waste water.

One problem with regard to drinking water that has been troublesome has been that of satisfactory provision of drinking water for field workers such as those employed on tobacco fields, road work, construction jobs, and similar undertakings.

Recently a new device has been manufactured consisting of a portable closed cylinder which may be filled with safe water. A drinking fountain is attached to the side of the cylinder and necessary pressure to supply the fountain is provided by a small hand operated air pump. Insulation aids in keeping the water cold and palatable. The container may be cleaned out periodically and sterilized by steam or disinfected with chlorine solution. —Connecticut State Department of Health *Weekly Bulletin*, February 23, 1937.

A Home-made Sleeping Bag

For a warm baby in a cold room

By EFFIE BEACHY GEIGLEY, R.N.

In rural districts particularly, where heated sleeping rooms are the exception, it is often difficult to keep the baby warm at night.

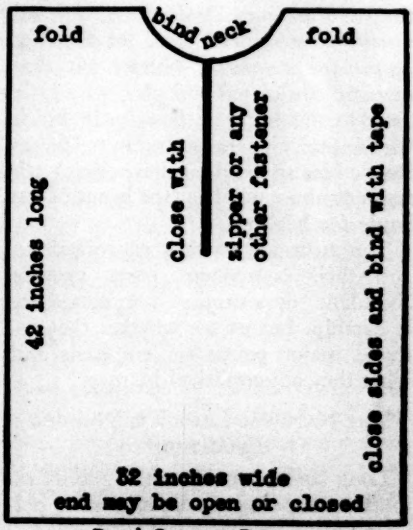
After several unsatisfactory trials of numerous sleeping garments on the market, I solved the problem by devising a simple sleeping bag of blankets for the baby.

Two large-sized baby blankets sewn together would answer the purpose very nicely. However, our sleeping rooms were exceedingly cold, so I selected a heavy cotton bed blanket of single-bed size, from which I made two blanket bags thirty-four inches wide and forty-two inches long. Seams were either flat felled or sewn on the outside and bound.

The blankets were closed all around and opened in the center back, far enough to easily permit slipping the baby into and out of the bag. The opening can be closed with strong flat snap fasteners or a zipper. The neck was cut to fit and smoothly bound. No draw strings were used anywhere (I have a horror of the baby playing with the strings and choking herself). Since the baby sleeps all night from six to six I saw no advantage in having the blanket open at the bottom, but it might prove so for younger babies who are fed and dried at night. I also found it convenient to use an open-bottomed blanket over her outdoor wraps when taking a nap on the porch or simply getting an airing.

This size blanket is wide enough to permit the baby to lie prone on her face, with both arms outstretched, which is our baby's favorite sleeping position. When wearing the blanket bag over a "sleeper," she is snug and warm all over all through the coldest nights, with her window open. It is next to impossible for her to kick off her covers when so clad, and even if she did get the top covers off, she is still well protected underneath. Although our sleeping rooms were close to zero lots of nights, I never found the baby cold except for her cheeks and what a satisfaction it was to dig her out of her covers warm and snug with her cheeks rosy and her eyes shining!

It adds greatly to my peace of mind to know that she cannot become entirely uncovered and so regardless of how much she crawls about she can't get chilled, and we both get a good night's sleep.



Baby's Sleeping Blanket

Composite Leadership

In 1937

In his address at the Silver Jubilee dinner of the National Organization for Public Health Nursing, Surgeon General Thomas Parran said:

> I would only remind you that among the reasons why the light from the lamp of Florence Nightingale shone far was because she was known to be perfectly ready to throw it at anybody who stood in the way of righteous progress. She is remembered for the good works of a saint, but she achieved those good works because she had a clear eye, a pungent tongue, and a heart so filled with wrath at needless suffering that she spared no one, no matter how highly placed, who might be responsible for it. Individually, there are few of us who can be Florence Nightingales. Our little voices would be lost in the contemporary din. Compositely, through the organizations which represent us, we can all have a part in leadership. If we lead fearlessly, our works also will be remembered.[1]

Lest major emphasis be placed upon the minor plagues, Dr. Parran impressed upon his listeners the need for selecting *points for emphasis*. Nurses left that meeting stimulated and perhaps a little awed by the extent of the areas in which the Surgeon General of the United States Public Health Service believes that well-trained nurses will bear the brunt of the battle for health.

The national nursing organizations, and their component parts, provide abundant opportunity for composite leadership. Let us see whether they selected major points for emphasis and what they accomplished in 1937.

The National League of Nursing Education

Long before Dr. Parran so pithily remarked that "appropriating bodies, politics aside, are generous to concrete services and little impressed by theoretical benefits," the National League of Nursing Education and the American Hospital Association, through a joint committee, were at work on a study of the technics necessary to ascertain the costs of nursing education and nursing service.

A program for accrediting schools of nursing on a national basis has been launched, under the direction of a special committee which has a body of distinguished consultants, as noted in last month's *Journal*.

Record forms for schools of nursing may now be secured from the League (prices sent on request). They are the result of much painstaking testing by a special committee of the League.

Because the quality of nursing service received by the public is dependent, in considerable measure, on the interpretation and enforcement of the legal requirements controlling the practice of professional nurses in the various states, an institute on state board problems preceded the annual meeting of the League held in Boston in May.

The *Curriculum Guide for Schools of Nursing*, published in July, has become such a professional "best-seller" that a reprinting has become necessary. The *Basic Book List* and the *List of Illustrative Materials* are useful additions to the ever growing list of manuals provided by the League for the assistance of those who direct or participate in nursing school programs.

Membership steadily increases and in 1937 reached 4,574. Some aspiring schools of nursing have 100 per cent faculty

[1] The entire address is reprinted in the November 1937 issue of *Public Health Nursing*.

membership. Many another would be well advised to make that one of the goals for 1938, in order that larger numbers of nurse educators might have the stimulating experience of composite leadership.

The American Nurses Association

The American Nurses Association closed the year with an all-time high in membership—138,297 (as of December 13). It is an awe-inspiring figure when taken in connection with Dr. Parran's stimulating concept: "Compositely, through the organizations which represent us, we can all have a part in leadership."

The ANA, however, made the same point in *The American Nurses Association and You*, that extraordinarily effective pamphlet of which over 120,000 copies have been distributed and widely used. Compare with Dr. Parran's the ANA's own statement:

> To the student of social and economic problems, it is very evident that in their professional organizations nurses have the instruments best fitted to improve every phase of their working and professional lives.

Institutes for secretaries and executive secretaries of state associations were held in New York and Chicago. The ANA provided this type of opportunity for representatives of state associations to share their thinking about "points of emphasis"—in other words, about the programs of the state associations in relation to national resources and planning.

No participant could emerge from such conferences without a clearer notion of what constitutes a major—as distinguished from a minor—objective, and a determination to work coöperatively for those things which mean most to the most people within and without the profession. What are *your* plans for the year? For five years? What is your long-term objective? These are the questions which executive secretaries and boards of directors ask each other. Usually they lead to consideration of two major functions: (1) the setting up of a program; (2) the collection of data for use in developing that program.

The profession has more precise data about itself and its members than have ever before been available, but many programs are still being built upon the shifting sands of wishful thinking instead of upon a secure foundation of social and economic facts.

Out of such conferences it may be expected that the resources of the national and state organizations will be more widely used, that programs will be more clearly defined and more expeditiously carried out.

A study of salaries and incomes begun in 1936 was completed in 1937 and will be published shortly. Efforts toward securing a reasonable time schedule for all nurses have been continued, with a resulting marked increase in the number of hospitals providing the eight-hour day for private duty nurses.

A study of private duty nursing was initiated. It is a grievous thing that so many private duty nurses distrust questionnaires because they fear reprisals, for there can be no "come-back" to an unsigned questionnaire. Such studies provide a perfect opportunity for private duty nurses to have a part in the "composite leadership" of professionally organized groups. The addition of a private duty nurse to the ANA Headquarters staff has been cause for rejoicing in this and other groups.

Registry studies have been continued and reported monthly in the *Journal*. These constitute an extraordinarily effective index not only to social and economic conditions among nurses but to the influence of general economic conditions upon nursing. The unimaginative, for example, might not associate with nursing a sit-down strike in the

steel or automotive industries, but the registrars in the towns so afflicted point to the swift drop in calls for nurses when such an economic disaster as a strike occurs. The registry studies provide the answers to many of the most important questions arising in the private duty field.

Is employment of private duty nurses increasing or decreasing? This is a question young graduates will do well to study before choosing to enter that field. The reports show, as a matter of fact, in the registries reporting, that whereas a monthly average of 32 per cent of the registrants worked twenty days or more in the first nine months of 1936, for the same period of 1937 the number had increased so that an average of 35 per cent of registrants each month were working twenty days or more.

Constantly on the alert to protect the public from unqualified persons practicing as nurses, the ANA was successful in securing modification of a federal program which would have created a body of unsupervised housekeeping aides to assume certain nursing duties.

Nothing in our recent professional history is more striking than the growth of graduate staff nursing, as pointed out in the study made by the Nursing Information Bureau and reported in the December *Journal*. Of 891 institutions providing data, in 1937, 88 per cent employed graduate staff nurses, as compared with the nearly two-thirds of the schools (of nursing) which in 1932, according to the Grading Committee,[1] did not have even one graduate nurse for bedside nursing. This is a truly remarkable development in the five-year period.

The ANA has provided stimulating guides to effective planning of programs for alumnae and district associations. The use of the word "programs" is here definitely associated with plans for meetings. In the larger sense of the word, the program of an association comprises all of its activities, those of its board of directors, and its committees, and its researches, as well as its formal and informal meetings.

The widespread interest in the vocational materials prepared by the Nursing Information Bureau shows a real hunger for readily available information about nursing. Here the importance of facts about nursing and the need for more precise data pops up at every turn. The public is quick to detect the weaknesses of generalities, no matter how glowing. If nursing wants, as it undoubtedly does, a clearer understanding of its function in society, of the preparation necessary for effective nursing service, of the needs of the individuals who make up this profession, it must secure more factual material for the use of those who are charged, either locally or nationally, with the responsibility for programs of public information.

Some of the state associations and state boards of nurse examiners have long since discovered all this for themselves. When the New York State Nurses Association, for example, goes before the legislature in January for an improved nurse practice act, it has data to prove that the so-called "shortage" of nurses is not due to decreased numbers of nurses but to an increased demand. The figures are interesting. Here are some of them.

The board of nurse examiners of New York State issued 13,700 more certificates in 1936–37 than in 1926. There were 2,000 more nurses in active practice in private duty nursing in 1936–37 than in the well-to-do period of 1928–29. An increase of over 5,000 institutional nurses in the same period seems to be in accord with the national study of the Nursing Information Bureau. A number of other states are equally well informed.

If, as individuals, we are to play a worthy part in the composite leadership of the profession, the New Year brings a

[1] *Nursing Schools—Today and Tomorrow*, 1934, p. 180.

specific obligation to every state nurses association. This is a biennial year. National planning for nursing will be advanced—or retarded—by the decisions of the ANA House of Delegates. "How well informed are our officers and delegates?" "How effectively can we discuss, recommend, and vote upon matters of importance to our members?"

If every state were to renew its efforts to provide accurate information for all its members, reiterating or summarizing those things that seem to the few to be well established, but that may still be news to the many, if every state were to make early and careful plans for sending well-informed delegates, nursing history could be made at the biennial.

The *Journal's* work for the year is by no means limited to the twelve issues of the magazine which have gone out each month. Much thought has gone into plans, some of which are projected far into the future. That 3,000 subscribers were added between October 31, 1936, and the same date in 1937 is gratifying. Enthusiastic plans now in the making by some of the states seem to indicate that 1938 will far outstrip 1937, not only in the number of subscribers but, what is infinitely more important, in the use of the magazine.

In '37's Great Disaster

The American Red Cross Nursing Service is so closely allied with the national nursing organizations that a reminder of its magnificent service during the "most destructive flood in America's history" may not be amiss here. Thirty-six hundred nurses gave service in the flooded areas, where 300 emergency hospitals were set up to meet conditions which have been vividly described in the *Red Cross Courier*, from which we quote:

Found Dr. De Francois and five volunteer nurses on duty, working tirelessly. Two of the local nurses are worn out and must be released. Must try to find some place for some of them to rest tonight—but where? Every corner seems to be occupied. . . . .

We shall serve only two meals a day from now on—to save both time and food. I have no idea when or how we shall get more.

Twenty-six patients in the hospital today, some of them desperately ill. Two old people are dying! And we are much concerned about a little three-year-old who has lobar pneumonia and a temperature of 105. I went around this morning and gathered some exhausted old people up off the cement floor and put them in the hospital—likewise on the floor, but at least it's clean and less congested. Also weeded out all the sick and ailing ones and had them report to the hospital for a doctor's inspection and to have temperatures taken. Perhaps we may avoid an epidemic by such precautions.

The National Organization for Public Health Nursing

What a celebration of its Silver Jubilee NOPHN has had! Some of the tangible results are summarized in *Listening In* for December. Here they are:

Personal membership (an increase of more than 1,600; the goal was 10,000)	9,658
Life members (33 this year)	67
Agency members (23 new; the goal was 25)	340
Subscriptions to *Public Health Nursing* (1,000 more than last year)	7,431

To its list of publications, which are essential tools in the development of public health nursing, NOPHN has now added *Personnel Practices in Public Health Nursing*. This is a "report of current practice in a sample of official health agencies in the United States," which was made possible by a grant from the Milbank Memorial Fund. It may be said to be as impressive a contribution to public health nursing as the *Curriculum Guide* is to nursing education.

The influence of the Social Security Act is merely hinted at in the statement that 1,000 new public health nursing positions have been created under the provisions of the Act.

Coöperative Relationships

Each of the national organizations has so many coöperative relationships, usually through joint committees, that all cannot be enumerated, much less described. Outstanding among them is the Joint Committee on Community Nursing Service, which has made studies in three communities. Its suggestions for the organization of community councils on nursing service begin on page 44 of this *Journal*.

The League's work with the American Hospital Association on the costs of nursing education and nursing service costs has already been noted. So, too, have the relationships between the Committee on Accrediting Nursing Schools and a group of national organizations.

Work on minimum standards for nursing service which are approved by the American College of Surgeons is being carried forward by a joint committee of that association and the ANA.

Internationally

The *Journal* has devoted so many pages to reports of the brilliant Congress of the International Council of Nurses that only briefest mention need be made here. With the addition of the associations of Australia, Switzerland, and Roumania, the membership rose to thirty national associations.

The *International Nursing Review* has been reëstablished on a sound basis. It merits a place in every library devoted to nursing, whether university, nursing school, state, or local nursing organization.

The Florence Nightingale International Foundation, child of the ICN and the League of Red Cross Societies, is moving forward slowly but very surely toward the key position in the nursing world which it will one day occupy.

Pride in having an American nurse elected president of the ICN and in having that body choose this country for the next congress, is tempered by a decent humility. How and where the Congress can be fittingly entertained, how we can most effectively give of our professional best to the visitors who will come to us from many lands in 1941, are matters calling for early and spacious planning.

We Conclude

Far more nurses than are now members could profit by membership in the national nursing organizations, if they would become active participants in composite leadership. Membership campaigns, however, have little meaning unless provision is made for the participation of new members in well-planned activities. To the extent to which the national and local organizations have clearly defined objectives and dynamic programs for reaching those objectives, we may say, with Dr. Parran, "Compositely, through the organizations which represent us, we can all have a part in leadership. If we lead fearlessly, our good works also will be remembered."

Councils on Community Nursing

A step toward better community nursing service

By GRACE L. REID, R.N.

ARTICLES AND EDITORIALS have appeared in the official nursing magazines from time to time, discussing the development, purpose, and program of the Joint Committee on Community Nursing Service. This committee, composed of representatives from the three national nursing organizations and of non-professional members of social and civic groups, was organized with two main purposes in mind: (1) to analyze the need for more satisfactory nursing service, and (2) to study ways and means for meeting this need. In working toward accomplishment of these purposes, the members of the committee hoped to be able to offer practical suggestions to any community which might request assistance in the solution of its problem.

Many communities have considered it feasible to carry on the study of the activities related to the care of the sick and the problems that arise in carrying on such activities, through the organization of a representative *local* group composed of both professional and non-professional members and usually called a "nursing council." Many requests for assistance in organizing councils have come to the Joint Committee on Community Nursing Service from other communities that have realized the need for nursing councils, but have felt the necessity for some guidance in outlining its purposes, objectives, and qualifications for membership.

In an attempt to furnish usable information which may be helpful in such a situation, a subcommittee of the Joint Committee on Community Nursing Service presents the following outline, hoping that any group faced with the all too common problems in connection with nursing distribution at the present time, will find this material adaptable to its need.

TENTATIVE GUIDE TO ASSIST IN THE FORMATION OF A COUNCIL ON COMMUNITY NURSING

A. Introduction

A council on community nursing service should be composed of representatives from all elements in the community interested in nursing. Its purpose is to promote the best possible nursing service for the community, through studying the nursing needs and methods for meeting these needs, and through promoting adequate preparation of nurses for such service. The guide attempts to show the steps which should be taken in forming such a council.

Usually, first, a small group in a community becomes aware that nursing service is inadequate to meet all the needs. This group may represent users of nursing services, nurses themselves, or some allied community group. They talk over the situation and gradually a number of people may realize the problem. Then a meeting representing all interested groups may be called to form a committee for discussion of community needs. Representatives from the local recognized medical and nursing organizations should be included from the beginning. Points outlined below under "B. Analysis of the Situation" may form a basis for discussion.

The committee may form a more or less permanent council on community nursing at once and then proceed to work out measures for providing more adequate nursing service. Sometimes, on the other hand, the committee decides to begin with a survey of nursing needs and facilities for meeting them, and continue a committee for this purpose. Such a study almost inevitably shows the value of a council on community nursing and should result in its formation. Local conditions and opinions will determine which order of procedure should be followed. In either case, analysis and study of the local situation are important.

B. Analysis of the situation

I. Community problems which show the need for study
  1. Sick people without nursing care
  2. Dissatisfaction regarding the quality of nursing service now available
  3. Difficulties in meeting the needs, as expressed by nurses, doctors, hospitals and representatives of the public
    a) Cost of nursing service prohibitive in some cases
    b) Conditions of employment not always satisfactory
      (1) Hours too long
      (2) Salaries too low
      (3) Living conditions not conducive to good service
    c) Distribution of nursing service may be uneven
      (1) Gaps in and duplications of services because of too many agencies, services not entirely covered by any one agency
      (2) Inefficiency of the registry, et cetera
    d) Lack of integration of service
  4. Confusion on part of public when situations arise which require nursing service
    a) Names of agencies confusing and often misleading
    b) Many agencies
    c) Functions of agencies not well understood by general public
    d) Procedures for obtaining help not generally understood

C. Area survey

I. Purpose
  1. To collect information and to make recommendations regarding
    a) Types of nursing service offered
    b) Types of nursing service needed
    c) Preparation of nurses required to furnish these types of service
    d) Distribution of nursing service
    e) Relationships among all agencies offering service
    f) Use of subsidiary groups such as "practical nurses," attendants, visiting housekeepers, et cetera

II. Method of survey [1]
  1. Direction
    a) Executive committee: A small executive committee of representative citizens and nurses should be appointed to supervise and guide the survey
    b) Director: If possible some qualified person outside the community should be engaged to direct the survey
  2. Participating groups
    Should assist in collecting data and should include
    a) Agencies distributing nursing services
      (1) Nursing bureau or registry
      (2) Hospital nursing services

[1] Assistance in making a community survey may be secured from the Joint Committee on Community Nursing Service (of the three national nursing organizations), 50 West 50th Street, New York City. Assistance in studying specific problems may be secured from the three national nursing organizations, i.e. registry or nursing bureau development, from the American Nurses Association; schools of nursing, from National League of Nursing Education; public health nursing, from National Organization for Public Health Nursing. The address of each is 50 West 50th Street, New York City.

(3) Public health nursing agencies
(*a*) Official
Department of health
Board of education (if it maintains its own school nursing service)
(*b*) Public health nursing association
Red Cross chapters
Tuberculosis associations
Others

b) Schools of nursing and educational institutions giving courses which prepare nurses for community service
c) Medical profession
d) Hospitals (hospital council, if there is one)
e) General education group
f) Social service agencies
g) Public at large
h) Statisticians. Often there are local people with this preparation who can give some time and should be able to render very valuable assistance in making the survey

III. Financing the survey[2]

1. The cost of an area study or survey would depend upon
a) Size of area to be studied
b) Number of agencies rendering service
c) Extent of survey
d) Amount of expert assistance from outside the area and the distance this person would need to travel to reach the community, the length of time spent there, transportation and maintenance within the area, and other incidentals
e) Clerical help
f) Amount of work done by local groups, et cetera
g) Other incidentals
2. Sources of income (may be from gifts and subsidies)
a) Community chest
b) Individual agencies
c) Professional organizations
(1) Nurses association (district or state)
(2) Medical society
d) Foundations
e) Community-minded citizens

IV. Information and publicity

If the area survey precedes the organization of a council on community nursing, a small committee should be appointed and held responsible for publicity on what is being done. It is understood that any publicity released should be previously approved by the executive committee. If there is a trained publicity person in the community who is interested in nursing it would be very valuable to try to have him on this committee.

1. Method
a) Short radio talks
b) Newspaper articles
c) Reports or short talks to interested groups
d) Inclusion of wide representation on committees and subcommittees
2. Materials
a) Facts and recommendation of study
b) Graphs and posters
c) Bibliography[3]

V. Recommendations

These should form the basis for further study and if the study has been done first, it is expected that the recommendations would include sug-

[2] An area study or survey of nursing needs and facilities is of sufficient importance to merit financial support of interested individuals and groups in the community.

[3] Bibliographies may be secured by writing to the Joint Committee on Community Nursing Service, 50 West 50th Street, New York City.

gestions for the formation of a council on community nursing.

D. Council on community nursing

I. Purpose

1. To provide the best possible nursing service to the community

II. Objectives [4]

1. To provide a meeting ground, through broad representation, for the discussion of matters affecting nursing service from the point of view of the public served as well as that of the nurse giving the service.
2. To give opportunity to study various problems from the point of view of all concerned, rather than from the viewpoint of isolated organization's needs.
3. To serve as a connecting link between the community, the agencies that provide nursing service and the nurse who gives the service, and thereby establish sound public relations.
4. To encourage the setting up of proper machinery to coördinate and distribute nursing service in a community so that there will be minimum waste.
5. To sponsor new types of programs of nursing service.
6. To interpret nursing to the community.
7. To interpret community needs for nursing service to
   a) Schools of nursing
   b) Agencies distributing nursing service
   c) Individual nurses rendering such service
8. To ensure adequate preparation for nurses for community service.
9. To stimulate the feeling of responsibility
   a) On the part of the community for
      (1) Supplying nursing service to the community
      (2) Education of nurses to render the service
   b) On the part of the individual nurse for the quality of service that is given
10. To stimulate interest and provide ways and means for research on mutual problems.
11. To furnish a means of education for various groups concerned.

III. Suggested steps in the organization of a council on community nursing: If an area survey has been made, Plan C-1 may be followed. If the organization of a council on community nursing is to precede an area survey, Plan C-2 would be wiser.

Plan C-1.—In Plan C-1 it is assumed the group invited to organize a council on community nursing is already conversant with the previous discussions on community nursing problems. It is also assumed that the endorsement and approval of the district (or state) nurses association has been secured.

Preliminary to the meeting which will be called for the purpose of organization, notices should be sent out asking the representatives of the various agencies to secure the approval of their boards of directors for the organization of a council on community nursing.

Procedure suggested for the organization meeting follows:

a) Call to order (by the person who called the assembly)
b) Statement of general purpose of the meeting
c) Election of *temporary* chairman
d) Election of *temporary* secretary
e) Adoption of resolution that council be formed (follow usual parliamentary procedure for motion, discussion and vote)
f) Appointment of chairman of committee to draft by-laws

[4] Adapted from summary of panel discussion of the Graduate Nurses Association of the District of Columbia.

g) Appointment of chairman of a committee to submit a ballot for permanent officers
h) Choice of date, hour and place of next meeting

Plan C-2 (preliminary meeting).—When the formation of a council on community nursing precedes an area survey, representatives from the various community groups should have an opportunity to discuss the various aspects of community nursing and the functions and need for a nursing council. They would then need to discuss with their own agency groups the proposal of organizing a council on community nursing and secure their approval. A small group of interested persons may invite representatives from all the interested community groups to a meeting for the purpose of the above-mentioned discussion.

The same procedure as in Plan C-1 from item *a*) should then be followed.

By-laws.—A suggested form of by-laws for a council on community nursing follows:

ARTICLE I

Name

Council on Community Nursing (?)

ARTICLE II

Purpose

To provide the best possible nursing service to the community (may be more specifically stated to fit particular needs if desired).

ARTICLE III

Membership

A. Representatives of all nursing service agencies. These should include executives and board members.
1. Nursing bureau or registry (professional)
2. Hospital nursing service
3. Public health nursing agencies
a) Official
(1) Department of health
(2) Board of education (if it maintains a school nursing service)
b) Non-official or private
(1) Visiting nurse association or public health nursing association
(2) Red Cross chapter
(3) Insurance company visiting nurse service
(4) Other

B. Representatives of nursing education field
1. Schools of nursing represented by principal and member of school committee
2. Department of educational instruction giving courses in nursing education, represented by director

C. Local professional nursing groups
1. District nurses association
2. Local league of nursing education (if there is one)
3. Local branch of state organization for public health nursing (if there is one)

D. Lay public. Representatives selected from among interested influential citizens. This group should comprise about one-third of the membership and should be composed of people keenly interested in community affairs.

E. Allied professional groups—representation selected from
1. Medical society
2. Hospital group through hospital council
3. Health department—health officer
4. Social service groups through the council of social agencies
5. Field of general education

ARTICLE IV

Officers

President (preferably a lay person), vice-president, secretary, and treasurer

ARTICLE V

Committees

1. Executive
a) Four officers and chairmen of the standing committees
2. Standing committees
a) Finance
b) Nominating
c) Program
d) Revision and membership
3. Others as necessary, such as
a) Public information
b) Research
c) Legislative, et cetera

ARTICLE VI

Meetings

1. Full council meeting held quarterly or on call
2. Standing and special committees meet regularly and as needed.

Other articles which may be added should include methods of election, length of term of officers, duties of officers, appointment of com-

mittees, notice of meetings, quorum. *Parliamentary Usage* by Emma A. Fox, published by Doubleday, Doran and Company, Garden City, New York, 1934, would be helpful in compiling by-laws.

This form is being offered only as a suggested guide and not a form to be followed. It is expected that every community presents problems and situations that make it impossible to fit into a set pattern. For example, in some communities it might be wise for certain reasons to limit the representation from each agency. The board of health might have a citizens' advisory committee which should be represented. Help and assistance in an advisory capacity may be secured from the Joint Committee on Community Nursing Service, 50 West 50th Street, New York City.

[This article is appearing simultaneously in *Public Health Nursing*.]

Nurses in Uniform in Public and in Advertising

The report of the Joint Committee of the American Nurses Association and the National League of Nursing Education To Consider and Make Recommendations Regarding the Problem of Nurses Appearing in Public in Uniform and for Advertising Purposes contained three principles which were endorsed both by the American Nurses Association Board of Directors and the National League of Nursing Education Board of Directors in June 1936. These are as follows:

I. The purpose of the nurse's uniform from the beginning has been the protection of the nurse.

In general, the nurse should wear the uniform only when engaged in the performance of professional duties. It should not be worn if it causes her to be conspicuous, as for example, when traveling with a patient and when it is necessary to appear in a public dining room.

II. Principles on the use of the nurse in uniform for advertising in magazines, newspapers, et cetera.

Nurses in uniform:

1. Should not be portrayed in adverising medicines because it is unethical for them to prescribe for patients, this being the prerogative of the medical profession.
2. Should not be shown as users of drugs, as self-medication is not encouraged among nurses.
3. Should not give testimonials nor permit signed photographs to be used for advertising of products for sale because this is considered unethical by the profession.
4. Should not smoke while engaged in professional duties, therefore, no illustration should be used picturing a nurse smoking in uniform.

(NOTE: The Committee believes that there should be no objections to pictures of anonymous nurses appearing in uniform in advertisements of firms selling nurses' uniforms.)

III. Principles on nurses appearing in uniform while engaged in non-professional activities.

1. If the nurse is employed by commercial agencies for professional services because of her professional knowledge and experience, she may wear the uniform as, for example, if she is a member of the staff of the health service in a department store or other agency, and as a consultant or adviser where her professional knowledge and experience are required. However, the selling of any product by nurses in uniform is not approved.
2. The nurse should appear in public only when dressed in an outdoor uniform such as that adopted by the Nursing Service of the American Red Cross, the United States Government Nursing Services and public health nursing associations.

What Is New in Nutrition?

By MARY A. BRADY

No OTHER MATERIAL has more of the new and change in it than the subject of foods and nutrition. To keep informed on its recent findings and scientific developments is important to anyone working in the field of health. Obviously it is possible in this paper to discuss only a small part of this recent knowledge, so we shall review rather briefly two phases: (*a*) recent nutritional findings of some of the minerals and vitamins; (*b*) list a few references which may be found helpful to the nurse.

Dr. James McLester, former president of the American Medical Association, in the September 11, 1937, issue of the *Journal of the American Medical Association* says:

> To emphasize any one food factor or group of factors is a dangerous thing. It is apt to lead to one of the greatest causes of nutritional failure in America, food faddism. I hasten to add that an exception should be made in the case of milk. The teaching should include instruction in the value of *each* of the foods and the place each should have in the diet, and emphasis should be placed always on the danger of the one-sided diet.

So while we are discussing only a few of the food factors in this paper, we are not minimizing the importance of a well-balanced diet which includes all essential food groups.

Three minerals stand out as being highly important: calcium, iron, and iodine. The reason for placing emphasis on these three is that unless we plan wisely for adequate amounts in the day's meals, they are apt to be present in insufficient amounts. Perhaps this is one reason why Dr. McLester says, in the article referred to above, that we should emphasize again and again the great value of milk. One quart of whole milk or about five ounces of cheddar cheese daily supplies sufficient calcium for the needs of the growing child. Unless sufficient milk in some form is included in the day's meals, it is difficult to meet the calcium needs of children and of adults by increased use of vegetables or other foods having much less calcium content, valuable though these foods may be otherwise.

In studies on iron content of foods we are concerned with the availability of the iron present as well as with the amount. While the iron content of some foods may be high and we would formerly have considered these foods to be excellent in their blood building quality, recent experimental studies have shown the availability of the iron in these foods to be comparatively low. Dr. C. A. Elvehjem and his co-workers at the University of Wisconsin have given us the following information regarding the availability of the iron in various foods.

Egg yolk	100%
Heart: Pork	86%
Beef	70%
Liver: Pork	66%
Beef	70%
Steak	50%
Oysters	25%
Cream of Wheat—no available iron	
Soy beans	80%
Navy beans	60%
Oats	57%
Wheat	47%
Yeast	47%
Apricots	50%
Parsley	22%
Spinach	20%

From this table it is clear that some foods which are high in total iron content may not give as much iron to the

body as some others with a lower iron content but with a higher availability. For example, while the iron of egg is 100 per cent available, there is only one milligram of iron present in an egg or about one-fifteenth of the day's need for a child. Dr. H. C. Sherman in a recent book says that iron is used more effectively in the body in the presence of a liberal calcium intake. This seems to be an additional reason for using enough milk. It has been found in a recent dietary study made in an eastern city that a free use of vegetables, whole wheat bread, and the cheaper fruits, with milk, resulted in a gain of 30 per cent in the iron content of the diet.

Iodine is an essential mineral in our diet, although we need only one part in about 3,000,000 parts of body weight. We may get it chiefly through its addition to drinking water and salt, in iodide tablets, and through the use of sea foods as salmon, cod fish, oysters, and cod liver oil. Interestingly enough milk, potatoes and oats grown in goitrous regions have more iodine in them than have other foods grown in these regions, although none of them has it in nearly sufficient quantity for the body's needs.

Much recent scientific information on the vitamins has been published from time to time, and shows the increasing necessity for recognizing their importance in the maintenance and recovery of health. Reports from all over the world show deficiency of vitamin C in our diets. This deficiency causes loss of resistance to certain types of infection as tuberculosis, and where too little vitamin C is habitually taken, certain symptoms appear such as loss of energy and fleeting pains in joints and limbs which often may be mistaken for rheumatism.

Vitamin A is found directly in foods as in the animal products of butter, cream, and cod liver oil; or in the carotene of green and yellow vegetables which has the power of forming vitamin A in our bodies. So we no longer speak of the vitamin A *content* of foods but rather of their vitamin A *value*. Many animal foods, as liver and milk, have both vitamin A and carotene. Some symptoms of vitamin A deficiency are lack of growth, greater susceptibility to respiratory infection, and night blindness. The latter may have a definite relationship to safety in night driving.

References

Boorrt, L. Jean: *Dietetics Simplified*. Macmillan, 1937.

———: *Nutrition and Physical Fitness*. Second edition, revised. Saunders, 1935.

Lowe, Belle: *Experimental Cookery*. Second edition, revised. Wiley, 1937.

Sherman, Henry C.: *Chemistry of Food and Nutrition*. Fifth edition, revised. Macmillan, 1937.

———: *Food and Health*. Macmillan, 1934.

———: *Food Products*. Third edition. Macmillan, 1933.

[Read at the Private Duty Nursing Section meeting, annual convention of the Wisconsin State Nurses Association, Ashland, Wisconsin, September 22, 1937.]

Hospital Council Aids Nurses

By F. S. DURIE

THE SAN FRANCISCO HOSPITAL CONFERENCE comprising all the major hospitals in San Francisco meets monthly to consider problems of mutual interest. In September of this year the Committee on Nursing of the Conference recommended that a study be made of the prevailing practices relative to hours of duty and the compensation paid to the general staff nurses employed in the hospitals represented in the conference.

A committee was appointed to secure the necessary information and to recommend whatever changes appeared to be in order. A questionnaire was sent to each of the hospitals. The committee secured information on the following points:

In your hospital

A. What is the rate of pay?
B. What perquisites are furnished?
C. How many hours per day do nurses work?
D. How many "days off" per week do they have?
E. Do they work straight or broken hours?
F. If broken hours, what are the usual hours?
G. Approximate number of general staff nurses employed?

Ten of the thirteen hospitals represented answered all the questions fully and promptly. Two did not answer. One replied that the number of nurses employed was too small to be considered. The returns are tabulated in Table I.

At the October meeting of the Conference, the committee made the following recommendations which were accepted unanimously by the Conference:

a) That general staff nurses be paid not less than $90 per month, plus meals and laundering of uniforms.

TABLE I

Hospital	Approximate Number of Staff Nurses	Hours per day	Days Off per Week	Straight or Broken Shift	Monthly Salary	Perquisites		
						Room	Meals	Laundry
1.....	30	8	1	Alternate	$75	x	x	x
2.....	94	8	1	Broken (D)	$75.50*	x	x	x
				Straight (N)	$85.50†		x	x
3.....	50	8	1	Broken	$80		x	x
4.....	40	8	1	Broken	$85		x	x
5.....	50	10	1	Broken	$86		x	x
6.....	33	9	1	Broken	$90		x	x
7.....	30	8	1	Broken (D) Straight (N)	$90		x	x
8.....	24½	8	1	Broken	$90		x	x
9.....	4	9	1	Straight	$90		x	x
10.....	45	9 (D) 9½ (N)	1	Broken	$90 to 100		x	x

* $73.50—room, meals, laundry.
† $85.50—meals, laundry.

b) That no general staff nurse work more than eight hours, within twelve hours.
c) That each nurse be allowed one full day off each week.
d) That three meals per day be allowed, but not more than one meal be taken on hospital time.

By this action of the Conference, hours of duty (which the study showed ranged from forty-eight to sixty weekly) were reduced to forty-eight for some 600 nurses employed in San Francisco's hospitals. The minimum pay was fixed for all the hospitals at the highest rate which prevailed in any of them.

The replies revealed also that all the hospitals were making a definite effort to put into effect a straight eight-hour day wherever it was possible. Nurses on evening duty, as a rule, worked from two-thirty to eleven with a half-hour for supper. Night nurses were on duty from eleven to seven. Nurses who worked between seven and seven in the daytime showed greater variations in their schedules. In the majority of instances, however, they worked a straight eight hours most days of the week. The reply from one of the hospitals, for instance, which employs an average of ninety general staff nurses showed that in any one day approximately fifteen or one-sixth of them worked broken hours. All others worked a straight eight-hour day.

It is believed that an eight-hour maximum day will tend to promote better health among this group, make them better nurses, and permit them to participate more freely in the activities and life of the community. In the long run, it is believed that the patient, the doctor, and the hospital will also be benefited.

Where There's a Will—

WE FELT THAT THE COURSE we were offering in bacteriology should be taught with more laboratory work and since we had only our hospital laboratory in which to teach the classes, we approached the dean of the school of education in a university located in our city, to find out if it would be possible for our student nurses to be taught the course in bacteriology at the university.

With the coöperation of the dean and the faculty of the university, we have worked out a program for the nurses to have two science courses, chemistry and bacteriology, taught at the university, making a full year of work (one subject each semester) with excellent laboratory experience. In February our intermediate students will begin their college course in psychology.

The instructors of the courses in chemistry and bacteriology come to our classroom for two lectures a week, Tuesday and Thursday mornings. On one afternoon a week, our students go to the university for four hours of laboratory work. Psychology will be taught in our classroom with visits to the clinic at the university.

As the college courses are added, the regular college tuition fees ($25 for each course) are added to the students' expenses. We hope to have anatomy and physiology taught at the university soon since we feel that this is a subject that needs adequate laboratory work.

The university gives our graduates thirty college credits for the three years of nursing school work, and three credits for each of the college courses taken during the three years, making a total of thirty-nine credits —a nice start for students who are looking forward to getting a B.S. degree.

EDITORIALS

Coöperation

A slogan for the New Year

We hail 1938 optimistically. There are so many evidences of a new type of co-operation among nurses and between nurses and allied groups that we may even be a bit behind the times in suggesting "Coöperation" as a professional slogan. We suggest it, anyway, for 1938, for there is much yet to do.

The report of a committee of the San Francisco Hospital Conference which is published on pages 57 and 58 of this *Journal* is one of the bright rays shining over the horizon of 1938. The American Nurses Association, for many months, has reported that difficulty in securing graduate staff nurses for hospitals has often been due to unfavorable working conditions, to the inadequate salaries offered, and to long hours. It is gratifying, therefore, to find that this committee in San Francisco has recommended an eight-hour day, a six-day week, and a minimum salary considerably above that which had prevailed in the area.

Mr. F. S. Durie, chairman of the committee and Superintendent of the University of California Hospital, writes that

> It is believed that an eight-hour maximum day will tend to promote better health among this group, make them better nurses, and permit them to participate more freely in the activities and life of the community. In the long run it is believed that the patient, doctor, and hospital will also be benefited.

Heads of nursing services, interpreting the problems and needs of staff nurses to the members of the Council, were probably indirectly responsible for that wholly constructive action. Careful interpretation and mutual respect have, as elsewhere, undoubtedly been the basis for this action.

A correspondent in another city writes of successive meetings of the Hospital Council, meetings of nurses and hospital superintendents, and meetings of the superintendents of nurses, before a similarly satisfactory decision was reached. This report states that, in one hospital at least, where a "shortage" had existed, there is now a waiting list. We must remember that the hospital superintendent has to defend every item in his budget to the governing board which employs him and that this requires time for the interpretation of the reasons underlying every increase.

On every hand, whether in our own profession or in social or political life, we hear two cries. One is for strong leadership. The other is for understanding, by other folk, of the needs of particular groups. Elsewhere in this issue we have pointed out the need for a factual basis for any program of public information. We now emphasize the need of respect for, and a coöperative attitude toward, the difficulties of other groups, especially those with which we are most closely al-

lied. We have, perhaps unconsciously, had the attitude of the person who said, "Coöperation is the thief of time," in reference to hours spent in conferences and committee meetings which seemed slow in producing results. Could time possibly be better spent than in developing that understanding which is the basis of coöperation?

A graduate council, now several years old, has been the means used in one university hospital to provide the graduate nurses with a means for aiding in the up-building of the service. Meetings, which the director and assistant director of nurses attend, are held monthly. Matters pertaining to the service and to the welfare of the nurses themselves are discussed. Nor do they stop with discussion. If action can be secured only through the superintendent of the hospital, the way is made clear by the action of the group itself. This is an institution which has no "shortage."

And here is how the principal of one school of nursing is building up a real understanding of nursing education, as the basis of everything that nurses do. At each meeting of her advisory committee she has one member of her faculty present some one aspect of the school's program. The questions which the lay members shot at the instructor in nursing arts, on her particular day, not only revealed a startling depth of ignorance about the very program they were supposed to be aiding, but laid the foundation for a wholly new type of coöperation and appreciation, based on understanding.

The *Journal* invites its readers to send in accounts of other adventures in understanding which turned out constructively.

Most of us are quite incredibly obtuse about other people's difficulties. Within the profession, with its need for specialization for certain well-defined purposes, most of us need to be reminded that no one group has all the problems or all the merit. It is along a united front, with respect for, and reasonable knowledge of, each other's activities, that we can best coöperate with that ever-demanding, never-satisfied, all-absorbing entity—the great American public.

Seven Steps for the Graduate Nurse

There are seven major steps to be taken by every graduate nurse along her road to professional fulfilment. Several of these steps must be taken immediately after graduation from a nursing school; others appear a little later and can be reached only after the first have been successfully mounted. The personal life plan of every graduate nurse should include them all. The seven steps for the graduate nurse (which were first defined by the Nursing Information Bureau in its most recent publication, Nursing and the Registered Nurse) ***are these: (1) state registration; (2) membership in professional nursing organizations; (3) enrolment in the American Red Cross Nursing Service; (4) survey of nursing activities and opportunities; (5) affiliation with professional placement agencies; (6) continued education in nursing; (7) provision for illness and old age. How many of the seven major steps have you accomplished or provided for in your personal planning?***

Ask Me Another

This is a nursing-intelligence test. The questions have all been answered in the Journal *during 1937. Write out your answers and then compare them with the answers found on page 113. Score yourself one for each correct answer. (Some questions require two or more answers—score one for each answer that is correct.) A score of 96 is possible; 75 is a good average; 90 is excellent. We'd like to meet the paragon who makes a score of 96.*

General

1. What are the sections of the American Nurses Association? (Score 2.)

2. How often is the Walter Burns Saunders Memorial Medal Awarded?

3. Who is the secretary of the Nursing Information Bureau?

4. Who is the executive secretary of the National League of Nursing Education?

5. What is the official magazine of the American Nurses Association and the National League of Nursing Education?

6. Approximately how many registered nurses were employed on WPA nursing and health projects at the peak of the program?

7. Does the *Journal* ever publish criticisms of nurses and nursing?

8. Who is the president of the National Organization for Public Health Nursing?

9. What are the dues for membership in the American Red Cross; in the American Red Cross Nursing Service? (Score 2 for perfect answer.)

10. Name the five federal government nursing services? (Score five for perfect answer.)

11. How many registered nurses are on the staff of the *American Journal of Nursing*?

12. Who is the general director of the National Organization for Public Health Nursing?

13. What three new member associations were admitted to the International Council of Nurses in 1937? (Score 3 for perfect answer.)

14. Who is the president of the National League of Nursing Education?

15. Is it necessary for a nurse to be registered in the particular state in which she resides or practices in order to be a member of the American Nurse Association?

16. Where can you find addresses of the nurses registries approved by state and district nurses associations?

17. What is the only insurance plan which to date has been endorsed by the American Nurses Association?

18. Where can you find the address of the state board of nurse examiners in any state?

19. Approximately what does group hospitalization cost the individual per month?

20. Name three new publications issued by the American Nurses Association in 1937? (Score 3.)

21. Did employment of nurses registered by professional nursing registries increase or decrease between 1934 and 1937?

22. Where will the next biennial convention of the three national nursing organizations be held; when? (Score 2.)

23. What is the position of the American Nurses Association regarding nurse membership in unions?

24. What three national organizations are coöperating in a study of nursing costs? (Score 3.)

25. Who is the president of the International Council of Nurses?

26. What nurse was added to the headquarters staff of the ANA in 1937; what state did she come from and from what branch of nursing? (Score 3.)

27. Where can you find news of transfers and new appointments in the government nursing services?

28. What is the length of the working day (or working week) for nurses, recommended by the ANA?

29. Who owns the *American Journal of Nursing*?

30. Is group hospitalization a form of state medicine?

31. Where can you find accurate current information about the employment of nurses through nurses registries in the U. S.?

32. What is the primary purpose of a nurse practice act?

33. Who is the director of Headquarters of the American Nurses Association?

34. What well-known university in the U. S. inaugurated graduate courses in public health nursing in 1937?

35. Where can you find lists of inexpensive pamphlets of interest to nurses and classified according to subject?

36. What is the official magazine of the National Organization for Public Health Nursing?

37. Who is the president of the American Nurses Association? Where is this information listed regularly? (Score 2.)

38. When was the first National League of Nursing Education curriculum published?

39. Name the Divisions of the American Nurses Association. (Score 3.)

40. What state nurses association published its history in 1937?

41. What important new publication was issued by the Nursing Information Bureau in 1937?

42. Is the trend toward the employment of more or fewer nurses?

43. Where are the headquarters of the three national nurses associations; where is this information listed regularly? (Score 2.)

44. What kinds of books are listed and reviewed in the *Journal*? (Score 2.)

45. What important survey of nursing service in hospitals was reported in 1937; what department of what nursing organization made the study? (Score 2.)

46. Who is the newly appointed executive director of the Nurse Placement Service sponsored by the Midwest Division of the American Nurses Association?

47. Who is the editor of the *American Journal of Nursing*?

48. What association is recognized by the federal government as representing organized professional nursing in the U. S.; how old is this organization? (Score 2.)

49. What three important books were issued by the National League of Nursing Education in 1937? (Score 3.)

50. What nurse was awarded the Florence Nightingale Medal in 1937?

Clinical

51. How much fluid should a patient with lobar pneumonia take daily?

52. What is the purpose of collapse therapy in pulmonary tuberculosis?

53. Which vitamin is particularly necessary for the best health of the eyes; what foods contain it? (Score 2.)

54. How does an increase in the amount of carbon dioxide in the inspired air affect breathing?

55. What is the essential difference in effect between protamine insulin and regular insulin?

56. Is the ultimate effect of alcohol as a beverage depressing or stimulating?

57. What age groups are found among the chronically sick?

58. Would you take a cathartic and apply heat to the abdomen for abdominal cramps; why? (Score 2.)

59. What new treatment for schizophrenia has been recently developed and widely used in this country?

60. What is embolism?

61. What is the effect of tobacco on the temperature of the skin?

62. How does an upper respiratory infection affect the carbohydrate tolerance of a diabetic patient?

63. What is homogenized milk?

64. What drug has recently come into use as a part of the treatment of morphine addiction?

65. When is a newborn infant regarded as premature (according to the standard adopted by the American Academy of Pediatrics)?

66. What is the normal blood sugar range?

67. At what stage in development is cleft lip and cleft palate normal?

68. Where is the phrenic nerve; what is its function? (Score 2.)

69. If a patient's excretion of phenolsulphonephthalein in the first fifteen minutes is 15 per cent, is his kidney function normal?

NURSING EDUCATION DEPARTMENT

Edited for the National League of Nursing Education by Claribel A. Wheeler, R.N.

Student Affiliation With A Public Health Nursing Agency

The National Organization for Public Health Nursing appreciates the fact that a growing demand is being made on public health nursing agencies to share in the basic preparation of nurses by offering opportunities for student affiliation. The organization recognizes its responsibility for suggesting ways in which such affiliations may carry out the spirit and purpose expressed in the Curriculum Guide.

Therefore the Education Committee of the National Organization for Public Health Nursing has outlined recommendations to serve as a guide for nursing schools and public health nursing agencies which are contemplating an arrangement for student affiliation and also for state nursing groups which hope to set up criteria for evaluating and approving opportunities for such affiliation.

It is intended that these recommendations shall be used in conjunction with the Unit on Nursing and Health Service in the Family in the Curriculum Guide for Schools of Nursing *published by the National League of Nursing Education.*

ELIZABETH FOX, *Chairman*

Education Committee, The National Organization for Public Health Nursing

INCREASINGLY, schools of nursing are seeking affiliations with public health nursing agencies as a part of the student's basic nursing education. Increasingly, public health nursing agencies are being pressed with demands for providing student experience, demands often beyond their ability to meet well. In many communities this affiliation has been carried on successfully for a number of years between progressive schools of nursing of accepted standards and well-organized public health nursing agencies. The program for the students has been carefully planned and has been recognized by the public health nursing agency as an education procedure.

However in other places the affiliation has not always been so successful. Schools of nursing whose standards have not always met those set up by the National League of Nursing Education have sometimes requested an affiliation in order to supplement an inadequate curriculum. Public health nursing agencies have too often accepted students, when their own staffs were small in number or unprepared to undertake the supervision of a student program, sometimes for the purpose of getting the work

of the agency done. This has been unfortunate for the student, for the school of nursing, and for the public health nursing agency.

Only when the affiliation is carefully planned for and carried out as an educational procedure does it prove a valuable experience for the student. The agency which undertakes to offer such an affiliation must be prepared to allocate a considerable amount of its supervisory and staff time to this enterprise and to have its own work correspondingly slowed up. Because of this, the agency has many times had to limit the number of students it can accept for affiliation. It seems advisable, therefore, that preference in accepting students should be given to schools of nursing whose standards are in accord with those set forth by leading groups in nursing education.

Because of the need for wise selection both on the part of the school and the agency, the Committee presents the following recommendations, based on the thinking and experience of public health nursing supervisors and instructors who have had many years' contact with student affiliation programs. It is suggested that before an affiliation is made in any community the school of nursing and the public health nursing agency study these recommendations carefully and undertake an affiliation only when these recommendations can be fulfilled.

Objectives of Student Affiliation

With respect to the student nurse's affiliation with a public health nursing agency, the *Curriculum Guide* says in part:

> This experience is not designed . . . as an introduction to the social and preventive aspects of nursing, nor as a specific preparation for public health nursing. It is intended rather to round out the student's nursing experience by having her meet some of the more common situations found in family health work and giving her practice in dealing with these situations.[1]

Primarily it should be considered as additional experience in the possibilities of including a health as well as sickness approach in nursing. The objectives of this particular affiliation, as listed in the *Curriculum Guide* are as follows:

1. To secure experience in applying to the home environment and family situation the nursing knowledge and skills previously acquired, including teaching skills.
2. To become acquainted with conditions and methods of treatment which are found more frequently in the home than in the hospital, such as work with expectant mothers, well children, and convalescent and chronic patients.
3. To learn how to approach the family, how to adjust to the situations found in the home, and how to guide the family in their efforts to facilitate recovery and maintain health.
4. To gain a wider knowledge of the health and social factors in family and community life as they relate to the maintenance of health and to the causes and treatment of disease.
5. To secure some practice in the use of community health and social resources and an appreciation of the interdependence of these agencies.
6. To have the opportunity for observing and understanding individuals of different age groups in their family relationships as a basis for a wider appreciation of human problems.[2]

Prerequisites for Affiliation

The school of nursing.—The student should have her affiliation in her third year and should have had the following:

A. Prerequisites
  I. Academic education
    1. A student should be at least a graduate of a four-year accredited high school
  II. Services in school of nursing
    1. Medical and surgical nursing, five months, preferably more

[1] Committee on Curriculum of the National League of Nursing Education: *A Curriculum Guide for Schools of Nursing*. National League of Nursing Education, New York, N. Y. Second revision 1937, p. 510.
[2] *Ibid*, pp. 512, 513.

2. Obstetrics, three months, including delivery room and post partum care of mothers and babies
3. Pediatrics, three months
4. Nutrition, theory and practice

B. Additional desirable experience
   I. Communicable disease service
   II. Out-patient department, one month—including prenatal and if possible, pediatric clinics
   III. Contact with the social service department of the hospital. It is important that the students have a knowledge of the functions and the operation of this department. It is suggested that this be obtained by (1) a definite plan of contact with this department throughout the entire curriculum by means of conferences in connection with the students' cases and family studies, or (2) a period of at least two weeks' observation in the department.
   IV. Theory and practice in nutrition should include, in addition to a knowledge of the fundamental principles of normal nutrition, instruction in family diet in relation to cost.

Preference should be given to those schools which provide service in psychiatric nursing and also to those schools which carry out a definite plan to incorporate the social and health aspects of nursing throughout the entire curriculum.

The public health nursing agency.—In order that schools of nursing may know what agencies are suitable for affiliation, it is recommended that some plan be made by the state board of nurse examiners in consultation with the National Organization for Public Health Nursing for the accrediting of those public health nursing agencies whose practices are in accord with accepted principles as outlined by the NOPHN.

A. Prerequisites for an agency offering an affiliation
   I. An affiliation should be sought only with agencies whose practices are in accord with the generally accepted principles of public health nursing and with standards of practice as outlined by the NOPHN,[3] as to:
      1. Organization
      2. Qualifications of nurses
      3. Personnel practices
      4. Salaries
      5. Supervision
      6. Procedures and technics
   II. No public health nursing agency should offer an affiliation unless it is prepared to accept an educational responsibility for the student. Wherever an affiliation is offered there should be one person responsible for the student educational program. In the large agency this may be the educational director. In a small agency the affiliation should be offered only when the nurse in charge is qualified, can take the full responsibility for the students, and can carry out the program in accordance with the recommendations that follow.
   III. The ratio suggested by the NOPHN of supervisors to staff nurses is one supervisor to eight or ten staff nurses, including students. This ratio—which is a minimum if there are students—is influenced by the preparation and experience of the staff nurses and

[3] See the following publications of the National Organization for Public Health Nursing:
Manual of Public Health Nursing. The Macmillan Company, New York, second edition revised, 1932.
Principles and Practices of Public Health Nursing—Including Cost Analysis. The Macmillan Company, New York, 1932.
Survey of Public Health Nursing. The Commonwealth Fund, 41 East 57th Street, New York, 1934.
The Board Members' Manual. The Macmillan Company, New York, second edition revised, 1937.

by the number of services carried by the agency.

IV. Experience has shown that it is not desirable for an agency to carry a ratio of more than one student to three staff nurses, if it hopes to maintain a safe, unbroken service to the community and offer a real educational opportunity for the students.

V. Qualifications of personnel
The qualifications of personnel should, with few exceptions, meet NOPHN qualifications for those appointed to staff and supervisory positions in public health nursing.

B. Type of organization
To date, most of the opportunities for student affiliation have been offered by visiting nurse associations with a generalized program. Experience has shown that the transition from hospital to home is made more easily by the student through the bedside service of the agency that offers a family health service. There is room for further experimentation in the field, however, by health departments and other agencies which meet these requirements.

ARRANGEMENTS FOR AFFILIATION

A. Health of the student
I. A physical examination should be made not more than three weeks before affiliation, with a report of any condition which might affect the student's health or the service. The examining physician should understand the reason for the examination and the nature of the service upon which the student is entering.

II. Immunization
1. Vaccination for smallpox and typhoid fever within the previous three years
2. Schick test, with diphtheria immunization if indicated
3. Dick test, where recommended by local health authorities

B. Length of affiliation
I. Eight weeks to two months in the senior year are recommended. Students should be introduced at regular intervals, thus permitting the public health nursing agency to plan a sequential program of instruction and practice.

C. Throughout the affiliation the student should not be on duty in the hospital.

D. Class work in the school of nursing should be arranged so that the student need not return to the hospital for this purpose during her affiliation.

E. An application blank for each student should be submitted by the director of the school of nursing and should include records of the student's educational background, nursing abilities, and personality traits, and a health record including a report of a recent physical examination.

F. The visiting nurse association should send the school of nursing an evaluation of each student, and a record of field experience and class work.

G. It is recommended that the public health nursing agency have frequent conferences with representatives of the school of nursing in order that the responsibility for the affiliation be shared and the programs of instruction be more closely correlated. To this end it is desirable that the faculty of the school of nursing should include representation from the public health nursing agency.

H. It is understood that the student should be maintained by the school of nursing during the affiliation. The public health nursing agency should be responsible only for transporta-

tion on duty and furnishing the bag and necessary supplies. The affiliating student should wear the uniform of the agency, or one acceptable to it.

I. It is desirable that a written agreement be made between the school of nursing and the public health nursing agency, covering the points discussed above.

PLAN OF STUDENT'S EXPERIENCE

Certain general principles governing the instruction are suggested:

A. There should be a carefully outlined plan for introducing the student to the field which should include:
   I. Observation of home visits with the staff nurse
   II. Demonstrations in the office or home. Some agencies prefer to give the demonstrations in the office with all the equipment available. In smaller agencies it is sometimes more feasible to give the demonstrations in the home. When this is done the demonstration should be followed by an office conference.
   III. Classes. Experience has shown that the necessary classroom instruction can be given in a period of from four to six hours weekly. In so far as possible, theory should be correlated with practise.
   IV. Frequent individual conferences with the educational director and supervisors.

B. Group excursions should be limited and are valuable only when special preparation for them is made both with the student and with the agency to be visited. Visits to other community agencies are most profitable when made by the student in connection with a specific case that she is carrying.

C. While it is desirable for the student to become familiar with the various services offered by the agency, this is not so important as that the student should be given the opportunity to carry a few cases over a long enough period for her to study the interrelation between health, sickness, and the family situation, and to plan and carry out, with assistance of the supervisor, a constructive program of health instruction and supervision in those families. Better results are often obtained by the students with cases that present comparatively simple health and social situations.

D. It is desirable that the student make one family study during the two months' period.

E. The method of having the student assigned to a selected district to work with the staff nurse in that district has proved to be very satisfactory for both student and staff. It increases the student's sense of responsibility for the community program and gives the staff nurse initial experience in supervision. This plan must be protected by careful selection of the staff nurse and close supervision by the supervisor and educational director.

F. The public health nursing agency should accept the responsibility for continuous supervision of students. Home supervisory visits should be spaced at such intervals as will make it possible for the supervisor to evaluate and promote the student's progress.

Student Enrolment Increasing

1935–1937

During the past year or more, hospitals have reported difficulty in securing sufficient nurses for general duty, registries have reported that they were unable to fill calls, and public health organizations have stated that they needed more qualified nurses for supervisory and teaching positions. Reports have come to the National League of Nursing Education that because of the closing of schools and also because of the higher qualifications required for entrance, the number of students was being reduced.

From the studies made by the Nursing Information Bureau, it is known that a majority of the schools throughout the country admitted more students this year than last, and that last year 71 per cent of the schools admitted more students than in the previous year. However, no information was available concerning the total number of students enrolled in all schools since January 1935. At that time there were 67,533 students in the 1,472 accredited schools in this country. Since that time the number of schools has decreased somewhat, for in May 1936 there were 1,399 schools, and in May 1937, 1,385 schools. Consequently it might have been expected that the number of students would be decreasing too, but this survey seems to prove that such is not the case.

Late in October of this year, the National League of Nursing Education, in an effort to get some definite information on this question, sent a postcard to each of the accredited schools asking for their total student enrolment as of January 1, 1936; January 1, 1937; and October 1, 1937; and also the number of students graduated during the years 1935, 1936, and 1937. The League is most appreciative of the coöperation which nursing school directors have shown in sending in this information, for data have been received from 90 per cent of the schools. In five states every school reported, and in twenty-four others not more than three schools were missing.

From this information it has been possible to estimate the total number of students in all schools at these various periods. From the actual schools in existence on January 1, 1935, and on May 1, 1936 and 1937, the total schools at the first of each year and in October of this year have also been estimated.

	Schools	Students
January 1, 1935	1,472	67,533
January 1, 1936	1,417	69,589
January 1, 1937	1,389	73,286
October 1, 1937	1,386	81,979

On January 1, 1935, there were about 67,500 students in the schools of this country. During the year 1935, the number of schools decreased 4 per cent, but at the same time the total number of students increased 3 per cent, so that on January 1, 1936, there were approximately 69,600 students in 1,417 schools. During the following year there was a smaller decrease in the number of schools, but a considerable increase in the number of students enrolled. Although there were 2 per cent fewer schools, there was an increase of 5 per cent in the total number of students with the result that 73,300 students were enrolled in 1,389 schools on January 1, 1937. In the two years from January 1935 to January 1937, the number of schools in this country was decreased by eighty-three. During the same period

the number of student nurses was increased by approximately 6,000.

In the 1,385 schools accredited in May 1937 and in an additional school opened this autumn, 82,000 students were enrolled on October 1. This is an increase of 12 per cent in the total number of students since the beginning of 1937. It is true that the October figures include new students entering nursing schools and that at the end of their preliminary periods a considerable number of them will be dropped.

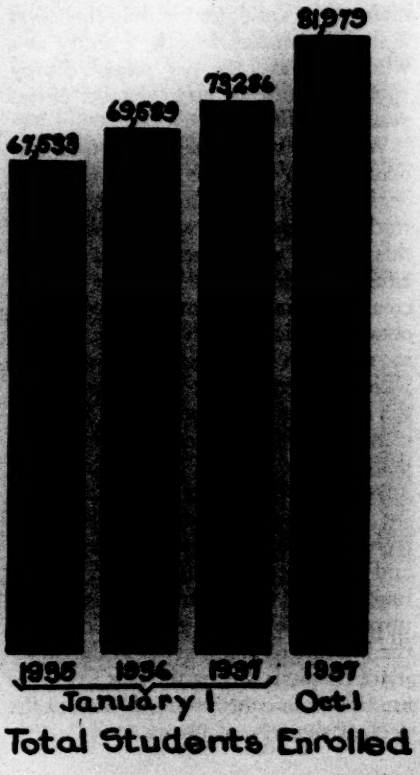
Because of more careful selection of students nowadays, however, fewer students are eliminated at the end of their preliminary periods than was formerly the case. It will be interesting to see how many students are actually in these schools on January 1, 1938; and although the 12 per cent increase which now exists between January and October 1, 1937, will undoubtedly be reduced, it seems evident that the year 1937 will show a considerably larger increase in total enrolment than that which was reported for 1936.

The table on page 70 shows the average number of students per school in each state on January 1, 1935; January 1, 1936; and January 1 and October 1, 1937. Possibly because of the incoming students in October, the average student body in every single state was higher at that time than at any of the other periods. However, on comparing the three Januaries, it seems significant that the average number of students per school was higher in 1937 than in either of the previous years in thirty-five states, and in four other states it was higher in 1937 than in 1936, but the same as in 1935. In only eight of all states were the 1937 figures less than those for either of the previous years. (New Mexico, because only one of its two schools reported, is not included in this count.)

On January 1, 1935, one-half of all schools had total enrolments ranging from twenty-four to sixty-two students. On January 1, 1936, half the schools had from twenty-five to sixty-five students; on January 1, 1937, from twenty-six to sixty-nine; and on October 1, from thirty to seventy-six students.

	Students per School		
	Q1	M	Q3
January 1935	24	39	62
January 1936	25	42	65
January 1937	26	44	69
October 1937	30	49	76

Whereas in January 1935, one-fourth of all schools had twenty-four students or less, in October of this year one-fourth of the schools had thirty or less students. Similarly in 1935, one-fourth of the schools had sixty-two or more students, while in October 1937, they had seventy-six or more students. For the past two



and one-half years there has been a steady increase in the size of the schools.

During the year 1935, 19,600 students were graduated from these schools. This was approximately 2,000 less than in the previous year and 5,000 less than in 1931. In 1936 the number continued to drop; only 18,600 were graduated that year.

For 1937, however, the picture has changed. We have reports only up to October, but during those first nine months 20,400 students have completed their nursing courses. This is an increase of 11 per cent in the number graduated during the first nine months of 1937 as compared with the total for the entire year 1936.

In thirty-five states more students were graduated per school in the first nine months of 1937 than in the entire previous year; in ten states the average remained the same; and in only three was it slightly smaller. For the country as a whole the average per school during 1936 was fourteen; up to October of this year it was fifteen.

With the steady increase in total students which has been evident since the beginning of 1935, and the increase in students graduated which has begun this year, it would seem that a definite effort is being made to meet the increased demand for nurses. Inability to obtain sufficient nurses has been due not so much to a reduction in students, which occurred in the early 1930's, as to the many new positions which have become available for nurses. The increased demand for nurses in public health nursing services under the Social Security Act, the growing prevalence of eight-hour duty for private duty nurses and for institutional nurses, the marked increase in the number of graduate nurses employed for general duty, and the increase of 119,270 beds in the capacity of hospitals during the past five years are the main contributing factors to the present shortage of nurses.

AVERAGE NUMBER OF STUDENTS PER SCHOOL*

State	January 1 1935	1936	1937	Oct. 1 1937
Alabama	29	32	35	39
Arizona	39	44	45	54
Arkansas	33	34	36	38
California	60	59	66	76
Colorado	47	47	56	62
Connecticut	73	78	81	86
Delaware	35	28	28	33
District of Columbia	87	84	88	93
Florida	40	41	46	51
Georgia	40	54	62	71
Idaho	27	30	32	34
Illinois	43	44	48	53
Indiana	53	54	60	69
Iowa	44	51	53	59
Kansas	27	33	35	42
Kentucky	37	44	47	48
Louisiana	52	79	80	92
Maine	30	31	32	37
Maryland	59	67	66	74
Massachusetts	56	60	59	64
Michigan	66	70	71	74
Minnesota	71	65	70	78
Mississippi	14	15	17	19
Missouri	52	53	54	62
Montana	31	37	46	53
Nebraska	52	52	53	60
New Hampshire	27	38	37	39
New Jersey	62	60	62	67
New Mexico	24	4*	5*	12*
New York	62	62	65	74
North Carolina	31	30	31	36
North Dakota	37	38	39	45
Ohio	55	57	60	67
Oklahoma	35	43	47	53
Oregon	49	52	56	74
Pennsylvania	54	57	60	67
Rhode Island	65	68	67	73
South Carolina	42	35	40	47
South Dakota	25	32	33	36
Tennessee	40	50	52	56
Texas	42	45	49	55
Utah	71	59	71	77
Vermont	31	29	31	36
Virginia	37	42	45	54
Washington	50	50	53	60
West Virginia	23	27	28	35
Wisconsin	52	59	63	73
Wyoming	30	33	29	35
United States	48	51	54	60

* Only one of the two schools in the state reported.

Illness—Students *vs.* Graduates

A summary of the first four months of the illness study appeared in the September issue of the Journal. *This is a report for the four summer months.*

BASED UPON data from 214 schools, the average amount of illness per student for the months, June, July, August, and September was 2.0 days. This is a decrease of more than a day and a half compared with the previous four months when the average illness per student was 3.6 days.

Among general duty nurses, the average amount of illness during the summer period was 1.6 days or one full day less than during the four spring months. General duty nurses were, on the whole, ill not quite a half-day less than students; in the spring term, they were ill a full day less.

During June the average student illness was 0.54 days, a decided decrease from the previous month. There was practically no change in July, but the decrease continued throughout August and September. Among the general duty group, considerably less illness was reported in June than in any of the summer months. For each of the four months, the average illness among graduates was shorter than among students, although, just as in earlier months, there were proportionately more graduates than students ill every time.

There was less variation in the amount of illness reported in the different sections of the country during the entire four summer months taken together than there was during the four spring months. Between that section reporting the heaviest and the one reporting the least illness among students, there was less than one day's difference, compared with nearly two and one-half days in the spring.

As will be seen in Diagram 2, New England again reported the heaviest illness among both students and general duty nurses. It is the only section of the country in which the graduate nurses were ill for as long as students. In the Middle Atlantic states, students were ill for 2.3 days also, but the general duty nurses were ill only 1.8 days. However, in both these divisions, the average days of illness for students and for graduates was higher than for the country as a whole. As in the spring months, least illness for both groups was reported in the East South Central and West South Central states. Compared with the average illness for the country as a whole, the Mountain states did not make so good a record during the summer as they did in the spring, while the Pacific states did better than during the previous period.

At the end of the next four months a

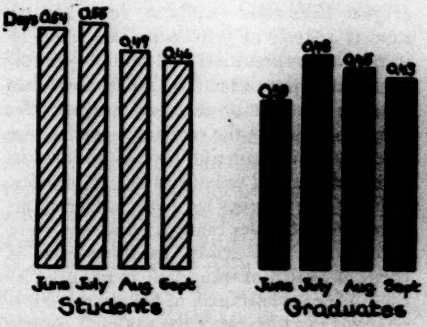


Diagram 1.—The crosshatched columns at the left show the average days of illness per student during each of the four months. The solid black columns at the right show the average days of illness per general duty nurse during the same months.

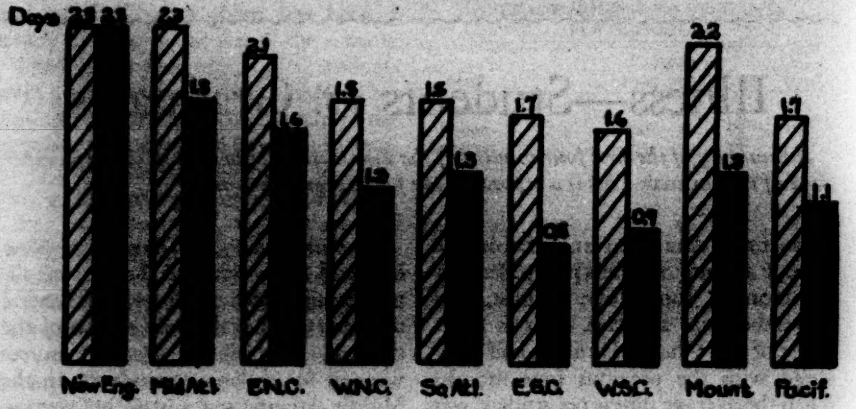


Diagram 2.—The crosshatched column in each pair indicates the average days of illness per student nurse during the four months, June, July, August, and September, in that particular section of the country. The solid black columns indicate the average days of illness per general duty nurse during the same period.

report for the winter period will be presented. The Committee is then planning to release a full report of the findings for the entire year, based upon data from those schools which have sent in twelve complete monthly records.

Two New Bulletins

NURSING SCHOOL ADMINISTRATORS will be interested in two bulletins recently published by the U. S. Department of the Interior, Office of Education.

Student Health Service in Institutions of Higher Education (Bulletin, 1937, No. 7) reports a study of provisions and practices in medical supervision and care in 352 colleges and universities. The report furnishes data on the cost of such services and the items included in the services as well as the extent to which nursing care is provided in these college and university health services.

Forty-one colleges for women having an enrolment of fewer than 500 students, were included in this study. In thirty-nine of them, a health examination is required of the student at entrance; in twenty-three it is repeated in each year of the student's course. In five colleges the initial examination includes a sputum examination.

In all these colleges except seventeen, the expense of the health service is included in the annual charge for tuition. In these seventeen schools, the charge for the service ranges from $1.50 (for general nursing care in the infirmary) to $25 (for services including physical examination, dispensary service for the entire year, immunizing inoculations, and treatment in the infirmary).

The cost of the service is estimated at various figures ranging from 50 cents to $37.22.

Trends in Secondary Education (Bulletin, 1937, No. 2) written by Carl A. Jessen, Senior Specialist in Secondary Education Office of Education, discusses significant movements and undertakings in secondary schools. Nursing school administrators will be particularly interested in the sections on "Providing for Individual Differences," "Vocational Education," "The Curriculum," "Tests and Measurements" and "Guidance."

Both bulletins can be obtained from the Superintendent of Documents, Washington, D. C. Price, 10 cents.

Teaching on the Wards

With applications to psychiatric ward teaching

By MARJORIE CLARK, R.N.

THE PURPOSE of this paper is to call attention to methods and possibilities for teaching on the wards of the psychiatric hospital and the value of such teaching to student nurses, to medical and nursing staff, and, indirectly, to the patient.

PLANNING WARD TEACHING

Every ward, whether in the general or in the psychiatric hospital, holds a wealth of teaching material which all too often is wasted because of lack of a definite plan for instruction. The value of a well-organized teaching program on the ward is obvious. In the classroom the student nurse is taught the classical picture of a disease, but she may not recognize that same disease picture when she meets it on the ward because of the variations it presents. She is taught the ideal way to carry out a procedure, but she must learn to adapt that procedure to the different conditions and types of patients which she encounters while nursing. She is taught the subject material but she must be able to recognize and apply its basic principles to the actual ward situation. How can she learn to do this? By connecting the theory of the classroom with its practical application on the ward by means of clinics, group demonstrations, morning circles, and ward conferences.

Organized teaching on the ward helps the student to see the patient as an individual instead of as a disease entity. An understanding of the social and economic background of the patient, as given in a case study or a doctor's clinic, helps the student to develop a sincere personal desire to help the patient recover. An unflattering comparison has often been made between the alive, growing interest of the probationer and the "just-another-day" attitude of the older student. One of the reasons for this attitude in the older students is the large number of routine duties which she performs and which are not in themselves particularly stimulating. The student's effort is in direct proportion to her knowledge of and interest in the patient. Each nursing duty should be an incentive to more advanced work and study. The nursing care of an alcoholic patient should increase the nurse's knowledge of such related subjects as the social aspects of alcoholism, alcoholism in relation to the assumption of adult responsibilities, or the effect of parent-child relationships upon personality development.

The supervisor derives as much value from ward teaching as does the student. Teaching keeps alive her interest in psychiatric nursing and in the student's progress; it helps her to evaluate more adequately the student's work; it promotes better student-supervisor relationships; it gives the supervisor an opportunity to solve nursing problems; and it ensures a uniformity of procedures and attitudes. Since the student spends three-fourths of her time with the supervisor or head nurse of the wards where she works, it therefore becomes the supervisor's responsibility and opportunity to guide and teach the student to the best of her ability.

Ward teaching is a supplement to classroom teaching and the ward is a

laboratory in which to apply the more formal type of instruction given in the classroom. It is here that the student puts into practice the knowledge which she has acquired. If she is an intelligent nurse and is interested in her work she can take the assimilated knowledge from class and study and apply it on the ward to the benefit of her patients.

How much better and more useful a nurse the student will be if helped and directed in her efforts by an understanding supervisor. In class the student learns the general characteristics of a mental disease such as schizophrenia, the attitudes to be assumed toward the patient, and the nursing care necessary; in her ward experience she finds a number of patients with a diagnosis of schizophrenia, no two of whom present the same clinical picture. Consequently, she must reorient herself to this disease, recognizing in each case the general characteristics of the disease varied by the personality of that individual, and must modify her general attitude to fit the needs of each individual patient.

Certain principles should be observed in the planning of a ward teaching program. A small group gives greater opportunity for effective teaching than a large one, for each member is given a chance to ask questions and encouraged to take an active part in discussion. The informal type of ward instruction holds the student's interest better and gives her more freedom to participate in discussions and to express her ideas. That ward teaching is time consuming must be recognized and the greatest economy of time ensured by careful planning. The supervisor who is heavily burdened with administrative duties will not have time to prepare for teaching or to teach effectively unless she is relieved of some of her duties by an assistant supervisor, head nurse, or a senior assistant. Housekeeping or clerical work can be efficiently done by other nurses or by well-trained attendants. In some hospitals, a ward instructor is employed to do ward teaching so that the supervisor is relieved of this responsibility.

The rotation of student nurses must be considered in planning ward instruction. The amount of time a student spends on each service should be based upon the educational material available through that service and not entirely upon the needs of the hospital. Although highly desirable, it is not possible for each student to have a practice period on a service corresponding in time to the lecture course covering that service. In our opinion, the second best plan is to give the theory first and then to follow it by practice, using ward teaching to connect the past knowledge with the present situation. The teaching should correspond to the nurse's class year in order to prevent its being too advanced for some of the group or too simple for others.

A room for ward clinics or demonstrations with the necessary equipment for teaching should be provided for each ward or, if the wards are small, one room may be utilized for several related services. Books and pamphlets relating to that service should be available for reference reading.

Individual Teaching on the Ward

Because the teaching of the individual student by the supervisor consumes considerable time, it is likely to be incidental and ineffectual unless it is based upon careful planning. Individual instruction is, however, necessary and desirable where the students are rotated singly from one service to another or where the number of students on a service is very small. Such instruction has the advantage of being easily adaptable to the problems presented by the individual nurse and by the patient or patients for whom she is caring. The following are ways of individual teaching:

1. Introduction of the student to the ward.
2. Explanation of ward records.
3. Conference on nursing experience record.
4. Discussion of efficiency or personality report.
5. Individual conferences with head nurse or supervisor.
6. Supervision of nursing case studies.
7. Explanation of behavior studies and sleep graphs.
8. Use of ward manuals and ward reference material.

The new student should be shown around the ward by the supervisor or head nurse so that she may become familiar with its facilities and get an idea of the type of patient on that service and the treatments given. This introductory instruction will save time by eliminating explanations when the student is giving nursing care during the busy part of the day. It also emphasizes the friendly, helpful spirit of the ward and lessens the emotional strain of a new experience.

The various records that are kept on that service should be explained so that the student will understand their value, how they are kept, and what her own responsibility is in the matter. If the type of charting done on that floor is new to the student it should be explained, for charting in the psychiatric hospital differs greatly from that in the general hospital.

Each student should have an experience record on which all the procedures and treatments which she is taught are listed. As the student satisfactorily completes a procedure the supervisor checks this on the chart. At this time she can make necessary suggestions or constructive criticisms to the student or, if desirable, give further instruction in that procedure.

Since the personality of the nurse is of major importance in psychiatric nursing, an efficiency report or personality record should be made for each student when she completes a service. These reports are of constructive value when used as a basis for the discussion of the student's successes and failures. They should be discussed with the student soon after they are made, while incidents on which they are based are remembered by both supervisor and student. Delayed examination of the report tends to create a feeling of resentment and unjust criticism instead of assurance that the supervisor is trying to help.

The adjustment of the new nurse to the problems presented in a psychiatric hospital is difficult. It can be facilitated, however, by individual conferences with the supervisor which should be held from time to time. They should be sufficiently informal for the student to feel free to bring up any questions she may have concerning the patients, the nursing care given, or her own progress. These conferences should provide a means of checking the student's knowledge of psychiatric nursing and of improving her work. They can also be used for individual demonstration of nursing procedures which were not correctly learned.

Case study is one of the best methods of individual teaching since it takes proportionately less of the supervisor's time and encourages observation and independent study on the part of the student. The study should include a word picture of the patient before and during his illness, the treatments and nursing care given, the emotional problems presented by this patient, and the methods found to be most effective in handling them. The material included in the study should be discussed with the supervisor to avoid misinterpretations of behavior or treatment. Emphasis should be placed on the student's observations and on the nursing care required. These studies may be submitted for grading but are most helpful when they are read to the group for discussion.

Behavior studies are particularly adaptable to a psychiatric hospital since the behavior of the patient is the most

important symptom of his illness. A study of the patient's reactions to his treatments, nursing care, doctors and nurses, of the ways in which he occupies his time while on the ward, and his attitude towards the restrictions of hospital life will offer many suggestions as to the most effective methods of caring for him. Similarly a sleep graph will call the student's attention to the factors which influence the amount of sleep the patient gets and to the comparative results of the sedatives administered.

The use of a pocket-sized notebook, often called a ward manual, which contains in abbreviated form the procedures and treatments used in the hospital as well as other important information, is helpful to the busy nurse. By this method she can refresh her memory in little-used procedures. The possibility of using many differing technics which are confusing to student and patient is avoided and time and effort are saved in preparing for and carrying out treatments. Preferably each nurse should have her own manual, but if this is not possible one should be easily accessible to all the nurses on a floor. These manuals may be revised frequently through staff conferences. Ward reference material should consist of books or pamphlets pertaining to psychiatric nursing which are available to the nurse both for reference and for more complete reading.

The Morning Circle

The morning circle, sometimes called the morning conference or report, is one of the most frequently used forms of ward teaching and, when well planned, it is highly beneficial to both student and supervisor. In its abbreviated form it consists of a report of the important happenings of the previous twelve to twenty-four hours and of the assignments for the day. Its helpfulness can be increased by including short topic presentations and discussions.

The morning circle helps the new student to adjust more readily to a service, gives all the nurses a uniform knowledge concerning the patients and the technics used, and stimulates their interest in psychiatric nursing. It should be planned and conducted by the supervisor or the head nurse, or, occasionally, by a student nurse; it should be attended by both day and night nurses. The room chosen and the conference should be out of the sight and hearing of the patients and should be unknown to them if possible. The time allotted to the conference will vary with the amount of nursing care to be given at that hour and the number of nurses on the service. At least five minutes are necessary for the abbreviated form and from ten to fifteen minutes for the topic discussion. How often shall these be held? Ideally they should be a part of the regular morning routine, but unless the ward is exceptionally well covered or the work light, it is probably more practical to have them semi-weekly. The following outline for a morning circle is suggested.

1. Night report, read by the night nurse. This is usually a brief routine reading of events of the previous twelve hours and discussion of any problems requiring the attention of the group.
2. Announcements.
3. Assignments for the day: assignment of nurses to patients with suggestions for nursing care; other work to be accomplished.
4. Assignment for next morning circle. This may be posted to save time.
5. Topic for presentation and discussion.

The topics selected for discussion should be directly connected with the nursing care being given, or with a problem pertaining to the present ward situation. If the topic selected is not of immediate and definite benefit to the nurse she will obtain little value from the discussion. The selection should be one of greatest interest to the majority of the group. Some topics of value for

ward teaching in a psychiatric hospital are:

1. A special treatment in use at the time such as fever therapy, spinal drainage, encephalography, or insulin therapy. Discussion as to purpose, procedure, nursing care and dangers involved.
2. Methods of inducing a specific patient to eat. Reasons for refusal, preparation and serving of food, and spoon-feeding.
3. Tubefeeding: preparation, administration, and precautions.
4. Wet sheet packs. Purpose, procedure, and nursing care.
5. Use of sodium amytal in mute, resistive patients.
6. Nurses' part in prevention of suicide.
7. Proper use of mechanical restraints.
8. Attitudes to assume in caring for a specific patient. Discussion of desired therapeutic aim on which these attitudes are based.
9. Admission routine.
10. Discussion of drugs now in use on the ward as to purpose, dosage, and methods of administration.

The assignment of a topic for presentation should be made at least two days in advance and should be definite as to the material included and the time allowed. References will be helpful, especially for the new student, and a list of important points to be covered will save time and clarify the discussion. The assignment may be posted on a bulletin board convenient for all the nurses but out of sight of the patients. The following is a suggested assignment.

ASSIGNMENT FOR MORNING CIRCLE

September 4, 7:00–7:20 A.M.

Topic.—Nursing care of Mrs. X, a fever therapy patient.

Previous preparation: by entire group.

References:

1. STILSON, GLADYS: Fever Therapy. *American Journal of Nursing*, February 1937, p. 164.
2. KOSAK, D.: Evaluation of Hyperpyrexia, Methods and Treatment. *Arch. Phys. Therapy*, August 1935, p. 481.
3. BENNETT, A. E.: Fever Therapy in Tabes Dorsalis. *J. A. M. A.*, September 12, 1936, p. 845.

Two-minute presentation by senior student: (1) Identification of the patient and her diagnosis; (2) indications for fever therapy in this patient; (3) types of fever therapy available and reason for type selected.

Five-minute presentation of junior student: (1) Nursing care of Mrs. X; (2) methods of controlling temperature curve.

Five-minute discussion led by supervisor based on the following: (1) Different types of fever therapy, advantages and disadvantages of each; (2) nursing care of patient preparatory to treatment; (3) principal dangers of hyperpyrexia treatments; (4) precautions observed in terminating treatment; (5) results to be expected from the treatment.

WARD CLINICS

The ward clinic is a more formal method of ward teaching applied principally to case presentations with emphasis on the nursing care. It offers the nurse a chance to see the patient and his illness in relation to the hospital or working situation. This graphic method has great advantages over reading or hearing a lecture on the subject. The ward clinic has the disadvantage of demanding a great deal of the supervisor's time for preparation and of the doctor's time for presenting the case.

In the usual method of conducting the clinic, the doctor gives a brief lecture on the case selected, covering the etiology, symptoms, diagnosis, treatment, and prognosis. Students should be encouraged to ask any questions they may have concerning the case. The doctor may then leave and the head nurse or supervisor continues with a discussion of the nursing care of this patient, including the purpose and technic of treatments received. The student's responsibility in the patient's care should be stressed. The student will receive more benefit from the clinic if she knows in advance which case is to be presented and has a chance to observe the patient. She may be given an outline form to follow and afterwards fill out for grading, or a ward reference reading to cover the case may be assigned.

The case selected should be one of gen-

eral interest to all the students and one known to the entire group. The number of ward clinics to be held in a week depends on the hour selected, on the amount of work on the service, the amount of time that can be given to the clinic by the doctor and the supervisor, and on the number of students. Where the number of students is small or the ward work is pressing, the clinics should be held about once a week. In larger wards where the supervisor has enough help to enable her to give the necessary time and where the number of cases is sufficiently high, ward clinics may be held three or four times a week. The clinic should be held during one of the slack hours, possibly ten and three o'clock in the average hospital.

Group Demonstrations

Group demonstrations are adaptable to such practical procedures as bedmaking, giving a wet sheet pack, applying sheet restraints, and tube feeding. They provide an economical and efficient method of teaching when followed by either a supervised practice period or a return demonstration by the student after a few days. Necessary equipment for the demonstration should be at hand and the steps in the procedure should be clearly fixed in the teacher's mind. The demonstration should be preceded or accompanied by a discussion of the purpose of the procedure, the preparation necessary, the comfort of the patient, and the responsibility of the nurse.

Summary

The value of ward teaching in its various forms in a psychiatric hospital has been presented. The different methods of teaching, including individual teaching, morning circle, ward clinics, and group demonstration, have been reviewed and the advantages of each method have been pointed out. The methods to be used in a psychiatric hospital must be determined by the teaching needs and by the facilities of that particular hospital.

Bibliography

Beal, Lucy H.: A Community Experiment in Ward Teaching. *American Journal of Nursing*, February 1927, p. 121.

Gabriel, Sister John: The Relative Value of Various Types of Teaching in Schools of Nursing. *American Journal of Nursing*, March 1928, p. 271.

Jensen, Deborah: Three Methods of Ward Teaching. *American Journal of Nursing*, October 1932, p. 1,077.

Marvin, Mary: Supervision: Methods of Increasing Ward Teaching and Improving Supervision. *American Journal of Nursing*, July 1926, p. 551.

Sleeper, Ruth: Teaching Methods. *American Journal of Nursing*, July 1935, p. 658.

Stratton, Alice: The Use of Ward Manuals of Nursing Procedures. *American Journal of Nursing*, April 1928, p. 339.

Therese, Sister M.: Clinical Demonstrations in the Teaching of Nursing. *American Journal of Nursing*, February 1928, p. 147.

Thielbar, Frances: Ward Teaching in a Mental Hospital. *American Journal of Nursing*, July 1934, p. 710.

Zelio, Margaret: The Morning Conference. *American Journal of Nursing*, September 1931, p. 1,053.

WHAT REGISTRIES ARE DOING

Eighty-four Registrars Report for October 1937

REPORTS FOR OCTOBER, 1937 were received from 84 registrars in 36 states, the District of Columbia, and the Territory of Hawaii.

Of the total number of calls received during October 1937, 94.33 per cent were for private duty nursing service; 5.17 per cent were for general staff nursing service; and .50 per cent were for other types of service.

Size of registry, represented by number of registrants

REGISTRANTS	REGISTRIES
Less than 100	34
100– 300	29
300– 500	10
500–1,000	8
1,339	1
Number not given	2

Hour schedules for private duty nurses as reported in October

8-hour duty predominates in 46 registries
12-hour duty predominates in 36 registries
20-hour duty predominates in 2 registries

Of the total 38,410 calls for private duty nursing service which were classified according to hours of service by 84 registrars, 66.78 per cent were for 8-hour duty; 26.97 per cent were for 12-hour duty; 3.16 per cent were for 20-hour duty; 1.16 per cent were hourly nursing calls; 1.73 per cent were for other periods of duty, and .20 per cent of the total number of calls for private duty nursing service were for unknown periods of time.

Hour schedules for general staff nurses as reported in October

8-hour duty predominates in 43 registries
10-hour duty predominates in 5 registries
12-hour duty predominates in 13 registries
Other hours of service predominate in 2 registries
Number of calls for 8- and 12-hour duty same in 1 registry
Number of calls for 8-hour duty and number of calls for which the hours of duty were unknown were the same in 1 registry
Predominating hour schedule unknown in 3 registries
No schedule was received from 16 registries

Of the total 2,105 calls for general staff nurses which were classified according to hours of service by 68 registrars (16 registrars did not report any calls for general staff nursing for October), 71.07 per cent were for 8-hour duty; 5.13 per cent were for 10-hour duty; 9.93 per cent were for 12-hour duty; 3.70 per cent were for other periods of duty; and 10.17 per cent of the total number of calls for general staff nurses were for unknown periods of time.

Increase or decrease in the number of calls for service of registrants in October 1937 as compared with October 1936

55 of 84 registries reported an increase
21 of 84 registries reported a decrease
8 of 84 registries did not give comparative figures on this question

The increase in October 1937 over October 1936 was 13.64 per cent.

The following reasons were given by registrars for an increase in the number of calls for nursing service in October 1937 as compared with October 1936:

Increased morbidity
Increased number of accidents
Improved economic conditions
Shorter hour schedules
Increased demand for 8-hour service, together with increased fees for 12-hour service
Enlarged hospital facilities
Coöperation of registrants through knowledge of functions of registry
More calls received from outside the city

Reasons given by registrars for a comparative decrease in the number of calls for nursing service were:

Decreased morbidity
Hospitals maintain their own registries and do not coöperate with bureau
Employment of nurses not listed with registry
Decreased hospital census
Fewer calls for private duty nursing service in one large hospital

Number of registrants on call during October 1937

The number of registrants on call per day and registries reporting are as follows:

Number of Registries	Registrants on Call
	Maximum
27	16– 40
26	40– 80
16	80–140
3	140–200
7	200–507
5	no report
	Average
36	8– 40
26	40– 80
8	80–140
4	140–200
4	200–341
6	no report
	Minimum
58	0– 40
11	40– 80
6	80–140
2	140–200
2	200–216
5	no report

Number of registrants called during October 1937

Registrants called for service per day and the number of registries reporting are as follows:

Number of Registries	Registrants Called
	Maximum
15	5– 10
26	10– 20
20	20– 40
13	40– 80
3	80–120
1	185
6	no report
	Average
42	1– 10
18	10– 20
10	20– 40
6	40– 80
1	138
7	no report
	Minimum
59	0– 10
11	10– 20
4	20– 40
3	40– 79
7	no report

Gratuitous nursing service

Thirty-three registrars reported gratuitous nursing service given during October 1937. The number of registrants in these 33 registries ranged from 1 to 25 with a total of 183 nurses giving 583 days of free nursing service.

Reasons for inability to fill calls

The following reasons were given by registrars for inability to fill calls for nursing service during October 1937:

Available registrants not prepared to give re-

quired service; unable to speak required language (Italian)
No physician in attendance
Request for specific registrant
No registrants available for out-of-city service; for late night call

Number of calls filled

All calls for private duty nursing service were filled for the month of October in 57 of 84 registries reporting. Seven registrars did not state whether or not it was possible to fill all calls received.

All calls for general staff nursing service were filled for the month of October in 40 of 84 registries reporting. Seven registrars did not state whether or not it was possible to fill all calls received.

Days of service by registrants for October 1937

In 32 of 84 registries the maximum number of registrants worked 1–9 days
In 6 of 84 registries the maximum number of registrants worked 10–14 days
In 3 of 84 registries the maximum number of registrants worked 15–19 days
In 20 of 84 registries the maximum number of registrants worked 20 days or more
In 4 of 84 registries the maximum number of registrants worked the entire month
In 4 of 84 registries the maximum number of days of service of registrants was unknown
15 registries did not give comparative figures on this question

Of a total of 14,519 nurses reported by registrars as actively engaged in nursing service during the month of October:

9.37 per cent worked the entire month
22.44 per cent worked 20 days or more
15.63 per cent worked 15–19 days
16.01 per cent worked 10–14 days
21.88 per cent worked 1–9 days
The period of service for 11.54 per cent was unknown
3.13 per cent did not work at all

Reasons for unemployment

Registrars gave the following reasons for the unemployment of those registrants who had not worked at all during October:

Registrants limit service to certain types of nursing and hours of duty; refuse out-of-town calls; accept only hourly nursing
Registrants not well known in community—recent graduates; out-of-town nurses; nurses who have not practiced in community for some time
A large number of available registrants, together with a limited demand for nursing service
Registrants difficult to place because of appearance; age; personality; inferior type of service
Certain hospitals do not call married nurses unless the need is urgent; also, in some instances, married nurses limit their service because of their family responsibilities
Limited demand for men nurses

Classification of service

Of 84 registrars reporting for October, 74 were able to list more or less fully the classification of nursing service for which registrants had been called in the community. The following table shows the various types of nursing service given by registrants:

Nursing Service	Calls	
	Number	Per cent
Surgical	17,736	48.98
Medical	8,256	22.80
Obstetric	1,871	5.17
Accident	811	2.24
Pediatric	779	2.15
Eye, ear, nose, throat	608	1.68
Genito-urinary	470	1.30
Communicable disease	445	1.23
Alcoholic	443	1.22
Orthopedic	316	.87
Psychiatric	309	.85
Tuberculosis	136	.37
Drug addict	19	.05
Hospital calls		
General staff (temp.)	1,675	4.63
General staff (perm.)	155	.43
Other hospital calls	115	.32
Classification unknown	1,404	3.88
Miscellaneous	661	1.83

Requests for services other than private duty and general staff nursing received during October included the following:

Superintendent of nurses
Registrant to take charge of small hospital
Assistant superintendent
Assistant director of nurses
Instructors—science, nursing arts
Charge nurse in children's tuberculosis preventorium

Personnel director (hospital)
Head nurses
Supervisors—medical; surgical; obstetric; delivery room; night
Surgical nurses
Office nurses—physician's office
Clinic nurses—orthopedic clinic; receptionist in medical clinic; preschool clinics
Social service—social worker in hospital
State health department—assist at demonstration of pneumonia serum
Public health nurses—assistant for insurance company nurse; infant welfare society
Industrial nurses—industrial first aid
Department of health education (hospital)
Nurses in King's Daughters Home; county home for poor; preventorium; Girl Scout camp (gratis); nursery school supervisor
Nurse permanently employed in hospital department of drugstore
First aid—at various local functions
Nurse to attend tea of town improvement society (gratis)
Demonstrator at medical convention
Registry relief
Dietitian
Anesthetist
X-ray technician
Switchboard operator in medical clinic
Housemother
Governess
Two hours teaching hygiene and sanitation in beauty culture college

Requests for particular preparation or service of registrants during October included the following:

Registrants with special preparation in care of alcoholic patients; psychiatric nursing; communicable disease nursing; obstetrics; pediatrics
Nurse experienced in giving fever treatment; in administering Elliott treatment
Registrants with special language qualifications
Nurses with experience in stenography, typing, bookkeeping
Nurses for registration desk and *Journal* table at the state nurses' association convention
Monitors for state board examinations
Registrant to administer anesthetic in home
Nurse to take charge of nursery
Nurses to accompany patients on trips—in one instance ability to drive a car was also required of the registrant
Nurse in good standing professionally with own car to make calls for insurance company
Nurse on duty for two days at opening of department store
Registrant to care for well baby

Hourly nursing service supplied

Of 84 registrars reporting for October 1937, 68 stated that the number of calls for this service ranged from 0 to 61 with an average of 6.87 calls per month.

Allocation of calls

In the 84 registries reporting for October, 83 were able to submit data relative to the allocation of calls for nursing service. The following table shows the percentage of calls received at the registry for nursing service "in the city" and "out of the city."

	In the City Per cent	Out of the City Per cent
Hospital calls		
Private duty	81.89	.68
General staff	4.63	.28
Other hospital calls	.40	.09
Home calls	7.92	.96
Miscellaneous calls	1.96	.04

The number of calls which were not classified according to their allocation was .15 per cent.

General staff nursing

Registrars gave the following reasons for inability to fill calls for general staff nursing service:

No registrants available for general staff nursing
Registrants prefer private duty because of more pleasant conditions of employment
Registrants not interested in general staff nursing out of city
Registrants unwilling to accept calls for week-end relief.

THE BOOK PARADE

Compiled by Ethel Wigmore

Order books from publisher or local bookstore. Address inquiries about books to the *American Journal of Nursing*, 50 West 50th Street, New York City.

Your Budget

Orchids on Your Budget, by Marjorie Hillis.

"Anybody can economize drably and untidily." The author shows "how to live smartly on what you have" and "how to economize with gaiety and an air." New York, Bobbs-Merrill, 1937. $1.50.

Making the Most of Your Income, by Harvey A. Blodgett.

Encouraging and sound, if not quite so smartly sophisticated and sprightly, advice on how to build a savings account from a small income; how to get the most from your job; good buymanship; et cetera. New York, Macmillan, 1932. $1.50.

Controlling Your Personal Finances, by David F. Owens.

Practical advice on "when, what, and how to budget, buy life insurance, borrow, invest, save, and spend." New York, Whittlesey House, McGraw-Hill, 1937. $2.75.

How To Beat the High Cost of Living, by Ray Giles.

"Eight hundred and sixty-four money-savers for everyday use." New York, Simon and Schuster, 1937. $1.00.

First Ladies

Madame Curie, by Eve Curie.

"Rarely—increasingly rarely—a book appears which reconciles us to belonging to the human race. Here is one." Clifton Fadiman. New York, Doubleday, Doran, 1937. $3.50.

Last Flight, by Amelia Earhart.

In this book shine clearly "the pervading charm and magic character of Amelia Earhart, whose explorings were as much of the mind and spirit as they were of the air." New York, Harcourt, Brace, 1937. $2.50.

This Is My Story, by Eleanor Roosevelt.

Frank, honest, humorous, and always interesting. New York, Harper, 1937. $3.00.

Queen Victoria, by Lytton Strachey.

A master biographer portrays the royal romance, the loneliness, and heartache of her middle age and the eccentricities of her last days. New York, Harcourt, Brace, 1936. (Big-books) $1.49.

Catherine the Great, by Katherine Anthony.

As lively and absorbing a piece of writing as one could ask is this life of eighteenth century Russia's first lady. Good background reading for Chevigny's *Lost Empire*. New York, Garden City Publishing Co., 1927. $1.00.

For Winter Armchair Cruising

Crossroads of the Buccaneers, by Hendrik de Leeuw.

Dullness and this book have nothing in common, for it is a diverting and informing account of the writer's meandering visits to that string of islands in the Caribbean known as the Windward-Leeward Chain. Philadelphia, Lippincott, 1937. $3.00.

I've Been Around, by Claudia Cranston.

"Seen and heard circling the globe in six months from New York to New York." A lively and entertaining travel book. Philadelphia, Lippincott, 1937. $2.50.

Half the World is Isfahan, by Caroline and C. LeRoy Baldridge.

This book, with its singing title, is a

realistic picture of modern Persia, not the Persia of Omar and the gardens of dawn, but an equally alluring land. New York, Oxford, 1936. $3.00.

The Southern Gates of Arabia.
The Valleys of the Assassins and Other Persian Travels, by Freya M. Stark.

Chronicles of strange humanity, strange and beautiful places seen along the "Golden Road to Samarcand" and the frankincense land. New York, Dutton, 1934. $4.00. New York, Dutton, 1937. $2.00.

Persian Pictures, by Gertrude Bell.

Written in 1894 by a young English girl, who was afterward to be known as "the great lady" by the Arabs, these glowing and exotic travel sketches are a delightful mingling of descriptive, poetic, and literary art. New York, Liveright, 1928. $3.00.

Guatemala, by Erna Fergusson.

Vivid impressions of Guatemala, old and new, of Mayan old empire, and modern Maya, of fairs and feast days. New York, Knopf, 1937. $3.00.

A Journey in Time: Peruvian Pageant, by Blair Niles.

A lovely tapestry of colorful stories and impressions of Peru's ancient past and exciting present. New York, Bobbs-Merrill, 1937. $3.50.

Fiction

Miss Buncle's Book.
Miss Buncle Married, by D. E. Stevenson.

Miss Buncle's flyer in literature is a novel, written under the name of John Smith. Into it she puts her entire village, unleashing thereby the fury of her townspeople. She escapes by marrying her publisher. Hilarious charm. Good for reading aloud. New York, Farrar and Rinehart, 1937. $2.00 each.

Victoria Four-thirty, by Cecil Roberts.

A vividly told tale of what happened to thirteen passengers, who board the 4:30 from Victoria Station, London, to make connection with the Orient Express. New York, Macmillan, 1937. $2.50.

This is Petra, by Alice Blackburn Dungan.

A tender fantasy about a lonely little orphan girl and her companionable shadow. For all those who haven't forgotten their own childhood. Philadelphia, Lippincott, 1937. $2.00.

The Diary of a Country Priest, by George Bernanos.

There is nothing romantic or sentimental about this story of a young French priest's work with the people of his parish. It tells us over and over again that courage, justice, honesty, humility—these are the great things of the world. New York, Macmillan, 1937. $2.75.

The Trojan Horse, by Christopher Morley.

A 1937 version of the classic story of the fall of Troy, and the immortal and tragic love of Troilus and Cressida. Philadelphia, Lippincott, 1937. $2.50.

Last Empire: The Life and Adventures of Nikolai Petrovich Rezanov, by Hector Chevigny.

The story of the all-consuming ambition of one man to push the Russian frontier beyond Siberia, Alaska, and down the west coast of North America. Set against a background of the glamorous court of Catherine the Great, intrigue, high adventure, love and, above all, thirst for power. New York, Macmillan, 1937. $2.50.

Crime and Punishment, by Fyodor Dostoevsky.

A world classic is this character study of the student Raskolnikov. "It may be taken quite simply as one of the most thrilling of detective stories, or as a drama of sin and redemption." New York, Macmillan, 1927. (Royal edition) $1.00.

Dead Men Talks Too Much, by Weed Dickinson.

A hard-boiled Hollywood mystery story involving a cinema queen. Philadelphia, Lippincott, 1937. $2.00.

The Return of the Blue Mask, by Anthony Morton.

The light-fingered, elusive, but always well-bred "Baron" comes back, causing no end of bafflement in Scotland Yard. Philadelphia, Lippincott, 1937. $2.00.

FREE AND INEXPENSIVE MATERIALS

Communicable Diseases

WILLARD PARKER TECHNIC BOOK. Published by the Willard Parker Hospital, Foot of East 15th Street, New York City. Price, $1.00.

This volume presents the rules observed by all persons having contact with communicable diseases in Willard Parker Hospital, the care and preparation of all types of materials and equipment, as well as outlines of routine nursing and medical procedures.

MEASLES, by Ethel B. Perry, price 10 cents; SCARLET FEVER, by Ethel B. Perry, price 10 cents; DIPHTHERIA, by Dr. George H. Weaver, price 15 cents; TYPHOID FEVER, by Edwin O. Jordan, price 10 cents; POINTERS ON POLIO, by Dr. Morris Fishbein and others, price 10 cents; SMALLPOX AND VACCINATION, by Dr. Jay F. Schamberg, price 15 cents; MENACE OF THE UNVACCINATED, by Dr. Victor G. Heiser, price 7 cents; UNDULANT FEVER, by Royall M. Calder, price 5 cents; CONTAGIOUS DISEASE CONTROL, by Harold B. Wood and W. W. Bauer, price 10 cents. Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

Each pamphlet describes the salient features of the disease discussed, giving authoritative information as to its cause (if known), signs and symptoms, methods of transmission, and advice about isolation, quarantine, et cetera.

A PROGRAM FOR STAFF EDUCATION—COMMUNICABLE DISEASE; A PROGRAM FOR STAFF EDUCATION—TUBERCULOSIS. Prepared and published by the National Organization for Public Health Nursing, 50 West 50th Street, New York City. Price, 10 cents each (free to members of the NOPHN).

These suggested outlines for staff study programs were prepared to assist groups of nurses and nurses working alone who wish to enrich their teaching and catch up with recent scientific development.

THE CONTROL OF COMMUNICABLE DISEASES. Prepared by the American Public Health Association, 50 West 50th Street, New York City. Price, 30 cents.

In this report of the American Public Health Association Committee on Standard Regulations for the Control of Communicable Diseases, each disease is briefly described with regard to the infective agent, the source of infection, the mode of transmission, the incubation period, and the period of communicability, and methods of control affecting the individual patient and his environment.

THE COMMON COLD. By Wilson G. Smillie. National Health Series, Funk & Wagnalls Company, New York. Price, 35 cents.

This booklet gives a wholly original handling of this important subject based on recent scientific tests and reaching new conclusions.

THE NURSE IN PNEUMONIA CONTROL, by Marion W. Sheahan, price 10 cents;

BIBLIOGRAPHY ON COMMUNICABLE DISEASES, price 10 cents (free to members of the NOPHN). Published by the National Organization for Public Health Nursing, 50 West 50th Street, New York City.

STUDIES ON ROCKY MOUNTAIN SPOTTED FEVER is a very comprehensive report of work done under the U. S. Public Health Service, 1930. Illustrated. Price, 35 cents. For sale by Superintendent of Documents, Washington, D. C.

THE HOME CARE OF COMMUNICABLE DISEASES. Published by the Life Conservation Service, John Hancock Life Insurance Company, Boston, Massachusetts. Free to nurses on request.

This pamphlet combines suggestions for care with information about communicable diseases. Other publications which may be secured from the Life Conservation Service of the John Hancock Mutual Life Insurance Company include leaflets on certain communicable diseases.

CARE AND PRECAUTIONS IN HANDLING CERTAIN COMMUNICABLE OR CONTAGIOUS DISEASES; HELPFUL SUGGESTIONS FOR THE CARE OF THE SICK. Published by the Metropolitan Life Insurance Company, New York City. Free on request.

These are two of the pamphlets in the Home Nursing Series which can be obtained by nursing school instructors and nurses engaged in public health education programs. A list of other health literature including pamphlets on certain communicable diseases can be obtained from the Welfare Division of the Metropolitan Life Insurance Company.

THE MENACE OF SMALLPOX; THE COMMON DISEASES OF CHILDREN. Published by the Prudential Insurance Company of America, Newark, N. J. Free on request.

Both of these pamphlets will be useful to nurses preparing to teach patients and their families.

"Summary of Current Prevalence of Communicable Diseases" and "Yellow Fever on Shipboard" are two articles published in the March 19, 1937, issue of *U. S. Public Health Reports*. Single copies of this weekly publication can be obtained for five cents from the Superintendent of Documents, Washington, D. C.

An article entitled "The Problem of Pneumonia Control" appears in the November issue of the *Statistical Bulletin* of the Metropolitan Life Insurance Company. Nursing schools may ask to be placed on the mailing list, without charge.

Many city and state departments of health furnish (1) regulations relative to the control of communicable diseases, (2) information on the management of these diseases in the hospital and in the home, (3) manuals for public health nurses. Write to your state and city health departments for these materials.

Pamphlets on certain communicable diseases are listed under "Disease and Ailments" in *Price List 72—Suburbanites and Home Builders*. Others are listed in *Price List 51—Health*, and *Price List 71—Children's Bureau Publications*. These catalogs will be sent free on request by the Superintendent of Documents, Washington, D. C.

In addition to these materials, see those listed in *Illustrative Materials for Use in Nursing Schools* (published by the NLNE) pages 29, 35, 44. See also the January and December, 1937, *Journals* (pages 116; 1399–1400) for other materials on pneumonia and tuberculosis.

STUDENT NURSES PAGE

Epidemic Meningitis

By YVONNE BOST
Washington University School of Nursing, St. Louis, Missouri

WHAT IS THIS NEW DRUG, sulfanilamide, prontylin? What a tongue twister! Almost everyone stumbles over its pronunciation the first time they see it. Did it really work, or was it too new to really know? In what kind of cases is it most suitable? In the last few months we are learning the answers to the questions which puzzled us not so long ago. We are finding out more and more that its results are as astonishing as its name—unbelievable at first and later expected. The use of sulfanilamide in Jerry's case was one of the first I watched from admission to discharge.

Little Jerry was three and one-half years old when he was admitted to St. Louis Children's Hospital last July. One was at once impressed by his apparently toxic condition; his carrot-colored hair seemed to make his small face all the paler and his large dark brown eyes more prominent. His skin was hot and moist. He was not completely prostrated, however, because he continually wished to sit up in bed. Most children, even when they are acutely ill, wish to sit up in bed and take part in some form of passive exercise such as coloring or cutting out paper dolls. Unlike adults, they cannot analyze their aches and pains but enjoy themselves as much as possible by forgetting about their illness.

His mother said the child had bathed in a country stream while on a picnic about a week before admission. There were other children there at the same time, but as far as is known none of the others showed symptoms of vomiting, prostration, marked irritability or rigidity of the neck. Jerry became sluggish and suffered from generalized malaise on the second day after the picnic. A nasal discharge was then noted and he was thought to be the victim of a "common cold." The mother did not become worried until five days later when he became nauseated and vomited every ten to fifteen minutes in small amounts for a period of several hours, after which it gradually decreased. He was then taken to the family physician, who found that he had an elevation of temperature and that he was very restless and irritable and toxic in appearance. He was hospitalized twenty-four hours after his toxicity became evident.

We do not know definitely that the country stream was the source of infection, but since meningitis is most commonly contracted when the organisms gain entrance into the body through the ear, nose, or mouth, it is possible that he did come in contact with the organisms in the water.

Epidemic meningitis is caused by a diplo-

coccus known as the meningococcus . . . . . Great variation is shown at times in the case and frequency of transmission. Most of the time epidemic meningitis exists as an occasional sporadic disease, but at other times it becomes widely epidemic. Approximately three-fourths of all of the cases of epidemic meningitis occur in children under ten years of age, and nearly half of them under five.[1]

Jerry does not lack financial security. Although his young parents are divorced, they are both working, and each contributes to the support of the child. At the present time he is staying with his maternal grandmother while the mother is working. His parents are very jealous of the child's affections and attempt to bribe him with toys and promises of visiting him more if he would say he liked each the better. Needless to say the child tried to carry over into his life in the hospital the same demand for attention which he had received at home. When he found that here we were sympathetic but firm and that he would be cared for as all the other children, he soon became adjusted to the hospital routine. During his convalescence he appeared to be a child of average intelligence and enjoyed playing with the toys brought him. Although he was very small, he seemed to have a sense of pride when his hair, skin, and teeth were well kept and clean.

As a whole, the admission physical examination was negative except for the enlarged tonsils, discharging nose, and infected right ear drum. His reflexes were tested and found to be hypersensitive; a slight rigidity of the neck was also found.

In Jerry's case the nasal discharge and the general malaise were the only symptoms of the first stage of the disease while the meningococci were in the blood stream. Later when the organisms had lodged in the meninges of the brain and the spinal cord, such symptoms as irritability and rigidity of the neck were noticed. The slight muscular twitching and a strabismus for two days in the second week of the disease meant that the inflammatory process had affected the visual area and the motor area of the brain. At this time Jerry complained of blurred vision and a great dislike for strong light. Such symptoms are not uncommon and, if the disease is not treated, they will become more serious, and either the child will be left with a permanent disability or death will occur. Because of this characteristic hyperesthetic condition, the child was kept absolutely quiet in bed. Creaking of the doors or windows, jarring of the bed, or excitement of any kind were to be avoided because the child in this stage of the disease is very sensitive to noises.

Jerry's was a fairly typical case of epidemic cerebro-spinal meningitis. The sudden onset accompanied by headache, vomiting, and a rise in temperature is the exact clinical picture. The other typical symptoms which Jerry showed were: irritability, restlessness, complaint of vague pains in the extremities, and the slight rigidity of the neck. His temperature was irregular and usually not excessively high. A high temperature is very temporary in this disease. Jerry's temperature rose to 39.5 degrees Centigrade soon after admission, but after that did not rise higher than 38.4 degrees, and it usually was around 37.5 degrees before it gradually became normal.

The most significant laboratory test was the testing of the spinal fluid. The accompanying chart shows the high cell count of 12,000 cells per cubic millimeter, and the rapid decrease after sulfanilamide treatment. According to Todd and Sanford, "The cells normally present are nearly all lymphocytes. They vary in number from 1 to 5 or 7 in each cubic millimeter; 10 is usually accepted

[1] Jeans, Philip C. and Rand, Winifred: *Essentials of Pediatrics for Nurses*. Second edition, revised. Lippincott, 1936, p. 357.

as the maximum in health."[2] The actual finding of the meningococci in the spinal fluid confirmed the diagnosis.

The treatment and nursing care of this child were very important, especially since he was to receive sulfanilamide. Jerry was weighed upon admission even though his condition was critical, because the dosage of sulfanilamide is calculated in proportion to body weight. He was found to weigh thirty-four pounds which is normal at his age.

Sulfanilamide grains five every four hours was ordered at first; six days later it was decreased to grains five three times daily. It was given orally, subcutaneously and intra-thecally (intraspinally). Since this is a new drug, a great amount of research is being carried on as to the correct dosage and how it should be given and for which cases; hence, the wide variance in dosage in the treatment of different diseases and in different periods of the same disease.

[2] Todd, J. C., and Sanford, A. H.: *Clinical Diagnosis by Laboratory Methods*. Seventh edition, revised. Saunders, 1931, p. 550.

This drug has appeared under various names, the name accepted by the American Medical Association being sulfanilamide. It has only recently been available on the market. Accounts of its forerunner, prontosil, appeared in German and French periodicals two years ago. The latter is a red dye, which must be given intravenously and, since it is thought to cause kidney damage, the equally effective drug, sulfanilamide, is being used in its place. The latter has the advantage of being less damaging to the kidney and able to be given orally as well as per needle.

Sulfanilamide was originally used to treat streptococcic infections. Both experimentally and clinically the drug acted as a bacteriostatic and a bacteriocide, and also apparently rendered the blood bacteriostatic and bacteriocidal. It is thought that the latter action is the one which is responsible for the curative effect of the drug in patients. The action against the meningococcus is probably the same as against the streptococcus.

Sulfanilamide Chart

Date	Amt. of drug *	How given	Amt. of spinal fluid withdrawn	Cell count per cu. millimeter
6-3-37.....	20 cc. 80 cc.	Intra-thecally Subcutaneously	20 cc.	12,000
6-4-37.....	45 cc. 155 cc.	Intra-thecally Subcutaneously	45 cc.	7,000
6-5-37.....	25 cc. 575 cc.	Intra-thecally Subcutaneously	25 cc.	3,880
6-6-37.....	24 cc. 325 cc.	Intra-thecally Subcutaneously	25 cc.	948
6-7-37.....	17 cc. 285 cc.	Intra-thecally Subcutaneously	15 cc.	456
6-8-37.....	4 cc. 95 cc.	Intra-thecally Subcutaneously	4 cc.	372
6-9-37.....	5 cc. 95 cc.	Intra-thecally Subcutaneously	5 cc.	104

* A 1 per cent solution of sulfanilamide in physiological salt solution was used.

The article by Dr. Perrin N. Long in the September *American Journal of Nursing* clearly shows the progress of the research in the use of the drug and of its chemical constituents.

The toxicity of the drug is not great if the dosage is properly regulated and the patient is carefully watched. Paleness, cyanosis, vomiting, dizziness, and headache are often common side effects of sulfanilamide therapy. Jerry's symptoms from the drug itself were cyanosis and paleness. His vomiting, headache, and dizziness disappeared soon after the drug had been used a few days and since the spinal fluid cell count was dropping also, those symptoms were thought to be caused by the disease itself rather than by the drug. Serious toxic conditions, shown by sudden high elevation of temperature, reduction in hemoglobin or white blood cells, warrants the immediate discontinuance of the drug. In this case, no unusual toxic symptoms were noticed.

It is the nurse's duty to have an accurate knowledge of the condition of her patient at all times and to see that he gets and actually takes his medicine on time. The latter is often a task, especially with children because of its bitter taste. However, Jerry, on the whole, took the medicine quite well.

The aims of nursing care in this particular case were: first, to maintain adequate isolation; second, to assist with lumbar punctures and the administration of sulfanilamide; third, to relieve symptoms by various nursing measures; and fourth, to attempt to understand the child in relationship to the environment from which he came.

It was necessary to prepare the child for his intra-thecal and subcutaneous injections of sulfanilamide solution. This was accomplished by telling him that he was going to be "pinched" just a little and that it would not hurt for long. If he would lie very quietly and let the medicine go into his body, he could go home all the sooner. Jerry was very coöperative and seemed to want to do everything that would make him get well sooner. The child was held in the routine manner for the lumbar puncture, but arm, foot, and chest restraints were necessary for the giving of the subcutaneous fluids, in order to keep the child from injuring himself or pulling out the needles. It was noted, as is usually the case in meningitis, that the spinal fluid was under increased pressure and cloudy in appearance during the first two days of hospitalization. After two days of sulfanilamide therapy the spinal fluid became normal in color and pressure.

It was difficult at first for the parents to fully understand that we had to maintain a rigid isolation. After carefully explaining to them why visitors were not allowed in the room, they became more coöperative. We taught the child that anything dropped on the floor was contaminated and that it must be washed and aired before he could have it again.

He soon learned to play with his toys without dropping them. All secretions from the nose and throat were carefully collected in paper handkerchiefs and disposed of by burning, and the linen and dishes were boiled after use. All those coming into close contact with the child wore gowns and scrubbed their hands in the routine manner.

To encourage Jerry's appetite was a real problem. His nausea, coupled with his irritability, made it necessary to use the utmost care while feeding him. All children are carefully supervised during meal time, but Jerry was even more so. His diet, which was the regular child's meal, was described to him a few minutes before the tray was brought in, so that he would be looking forward to it. An attempt was made to serve the food as attractively as possible, and the servings were very small, so that by finishing

his meal he would feel that he had really accomplished something. He was encouraged to feed himself, and soon he took great interest in his meals. At first he did not care for his milk, because he had had beer at home with his meals, but when it was explained that all the other children drank milk, he, too, enjoyed it.

Fluids were encouraged at all times to aid in eliminating the toxins of the disease. An accurate record of intake and output was kept, because of the possibility of kidney damage due to the injection of such large amounts of sulfanilamide.

Jerry's nausea stopped, his paleness decreased, his coryza and the rigidity of his neck disappeared gradually. The prognosis was very good when the child was discharged, since he had responded to treatment so well. There was no evidence of deafness, mental confusion, or deficient sight which might easily have occurred in a severe irritation of the meninges, such as is often present in cerebro-spinal meningitis.

This case is interesting to me because of the use of the new drug, sulfanilamide, and its possibilities in the treatment of different diseases. Before caring for Jerry, I had never helped with intrathecal administration of drugs combined with lumbar puncture. Since this disease makes the child extremely irritable and uncoöperative and since he was such a small child, one had to use nursing ingenuity and patience to cope with the new problems as they arose.

Bibliography

Best, Dorothy R.: Sulfanilamide and Nursing Care. *American Journal of Nursing*, Vol. 37, September 1037, pp. 950–952.

Blumgarten, A. S.: *Textbook of Medicine for Students in Schools of Nursing*. Second edition, revised. Macmillan, 1932, pp. 173–178.

Jeans, Philip C. and Rand, Winifred: *Essentials of Pediatrics for Nurses*. Second edition, revised. Lippincott, 1936, pp. 357–360.

Long, P. H.: Chemotherapy of Certain Bacterial Diseases. *American Journal of Nursing*. Vol. 37, September 1937, pp. 945–950.

Mellon, Ralph; Gross, P.; and Cooper, F. B.: Experimental Studies with Sulfanilamide and with Prontosil in Hemolytic Streptococcus Infections. *J. A. M. A.*, Vol. 108, May 29, 1937, pp. 1,858–1,861.

Todd, J. C. and Sanford, A. H.: *Clinical Diagnosis by Laboratory Methods*. Seventh edition revised. Saunders, 1931, p. 550.

Weinberg, M. H.; Mellon, R. N.; and Shinn, L. E.: Two cases of Streptococcic Meningitis Treated Successfully with Sulfanilamide and Prontosil. *J. A. M. A.*, Vol. 108, June 5, 1937, pp. 1,948–1,951.

Pamphlets on prontylin and sulfanilamide from Burroughs Wellcome and Company and Winthrop Chemical Company.

OUR CONTRIBUTORS

EVELYN LIN, NAC, Director of the School of Nursing, Soochow Hospital, Kiangsu, China, and President of the Nurses Association of China, is a graduate of the School of Nursing, Peiping Union Medical College, Peiping, Hopei. Miss Lin attended the International Congress in London in July and was taking post-graduate courses in New York City when she was recalled to China to give assistance in the present emergency.

EDNA PERRIGO, M.D., is a member of the Department of Medicine, Vanderbilt University, Nashville, Tennessee, and HARRIET KLEIN, Ph.B., R.N. (Presbyterian Hospital School of Nursing, Chicago, and University of Chicago), is Assistant Professor of Medical Nursing in the School of Nursing at Vanderbilt University.

Many nurses will be grateful for the exposition of the principles governing the action of respirators and vasculators provided by CARLETON J. LYNDE, Ph.D., Professor of Physics, Teachers College, Columbia University, New York City.

MARY ELLEN MANLEY, R.N., is Director, Division of Nursing, Department of Hospitals, New York City, and thus bore a heavy responsibility when the eight-hour day for hospital personnel was achieved at long last and it became necessary to increase by many nurses the nursing service in the city hospitals. This example of careful advance planning should be helpful to other executives.

At the time when the study of methods of approach to psychiatric patients was prepared, ELOISE SHIELDS, B.S., R.N., was director of the school of nursing at the Westchester Division of the New York Hospital (formerly Bloomingdale Hospital), White Plains, New York. MARGUERITE KENNEDY, R.N., was a head nurse and MRS. DORIS JONES, R.N., was an assistant head nurse in the same institution. Approval for the use of the case studies was given by Dr. Clarence O. Cheney, Medical Director of the Hospital.

ETHEL SYKES, B.S., R.N., is an English woman who received teacher's training in that country and in the United States, with special emphasis on the activities of young children. After graduation from the Geneva General Hospital School of Nursing, Geneva, New York, she occupied supervisory positions in the pediatric wards of Bellevue Hospital, New York City, and from 1933 to 1937 was supervisor of the children's pavilion, New York Hospital, New York City.

MRS. EFFIE BEACHY GRIDLEY, R.N., is a practical parent, as well as an experienced private duty nurse.

GRACE L. REID, R.N., is chairman of the subcommittee of the Joint Committee on Community Nursing Service which is formulating a tentative guide to help communities in the formation of councils on community nursing.

MARY A. BRADY is Extension Nutritionist, University of Wisconsin.

A most encouraging note is sounded in the article by P. S. DUNN, Superintendent of the University of California Hospital, and Chairman of the Committee on Nursing, San Francisco Hospital Conference and Association of California Hospitals.

The study on enrolment of student nurses was made at the headquarters office of the National League of Nursing Education.

MARJORIE CLARK, R.N., is Supervisor of Instruction, Menninger School of Psychiatric Nursing, Menninger Sanitarium, Topeka, Kansas.

THE OPEN FORUM

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered.

It Pays To Learn

Not so long ago, I found myself, like many other graduates, discontented with general staff and private duty nursing. I took a temporary position in a visiting nurse association and, liking the work, I applied for a permanent position.

I was most indignant when I was told that my practical work was good, but I needed more theory, and was advised to take a course in public health nursing. I wanted a change so I registered for a nine-months postgraduate course in public health nursing.

Well, today I have to look in a mirror to recognize myself. It certainly pays to learn what a vast field public health nursing is, to become acquainted with other health and social agencies and to know how to cooperate with them, to learn of many of the problems that confront directors of nursing services and their boards, and above all to learn the joy of "just knowing" (I have also discovered how little I really do know) and to have the earnest desire to know more.

Now I am about to apply for a position. I no longer feel that any organization owes me a living. I am interested in knowing the policies of the organization to which I may apply, and how I, as an individual, can fit into this service.

The moral of my tale is this: If anyone doubts your ability, take a good inventory of yourself; you may want to thank them, sometime, for their frankness.—E. E., R.N., Connecticut.

Whose Responsibility?

Who is responsible if a nurse's aide in a hospital, instructed by a graduate nurse, gives the wrong dose of medicine?—R.N., New Jersey.

No Shortage of Nurses Here

There is not a shortage of nurses in Southern California. Since August there has been a decided lessening in hospital census and in calls to the professional nurses bureaus. There are numbers of qualified nurses waiting for private duty calls.—Board of Directors, California State Nurses Association, District 5, Los Angeles.

Heresy or Honesty?

I am a healthy, active girl twenty-one years old. As a child I was sent to Sunday school, and took an active part in church activities. I was second vice-president of the Epworth League and led the program once a month. I always liked this. We also did a lot of social work, in which I was interested.

I belonged to the Camp Fire girls—I still try to do at least "one kind deed a day." During the last two years that I belonged, I was made assistant to the councillor.

I went through school as an average student. I always excelled in mathematics, English, and foreign languages. During high school I was in the glee club, dramatics club, and on the student council.

I had always wanted to be a nurse. When I found that I was ineligible to enter training because of my age, Dad decided to send me away to school for two years—if I was still insistent upon going in training, I could make my application then.

I entered a university in 1933 and spent two of the happiest years of my life there. I was on my own. No one was there to direct every decision. I studied hard and got good results. It was there that I learned how to study for I found that if I was not prepared, no one cared and it was I who suffered.

Then I came in training—oh, what a dif-

ference! I was no longer trusted to make my own decisions. I had to ask permission for this and for that. I realized the necessity for this and tried to make the best of it but I believe this was my first disappointment in nursing. It made me feel as if I weren't worthy of my word. But I could always hear Dad saying, "You made your bed, now lie in it," so I resolved to take everything with my chin up.

I enjoy my work and my classes, but I have lost much of my respect for nursing as a profession. I am told that I am an excellent student both clinically and theoretically, but I am thinking of entering another field where natural leadership, sociability, and honesty are less stultified.—A DISAPPOINTED STUDENT, Maryland.

Placing the Emphasis It is easier to add skills to attitudes than it is to add attitudes to skills.—LAURA BLACKBURN, R.N., South Carolina.

The Industrial Nurse's Contribution When the industrial nurse can see, behind a mask of dirt and grime, a fellow man who has the right to live even as herself and can feel in the gaze of tortured eyes an appeal that cannot be refused—what greater satisfaction could she wish than the knowledge that it is within her power and her capacity as a nurse to help some crushed body or broken spirit back to a normal, healthy life?

A nurse who offers her life to the service of industry must play the rôle of teacher, adviser, mother, and friend with unwaning interest in all times and can truly show her love of her profession in this manner. She helps to make industry safe for the people who have made America what it is today.—FLORENCE E. GILDEA, R.N., Georgia.

We Beg Your Pardon We misinterpreted the information received regarding the previous experience of C. Jeanette Oswald whose appointment as associate professor of nursing education at the University of Oregon Medical School, Portland, was announced in the December 1937 *Journal*. Miss Oswald has not had experience in public health nursing.

League Reports for Sale Anna C. Jammé, Inverness, Marion County, California, would like to sell a complete file of the *NLNE Annual Reports*, from 1903 to 1936, for $50.00.

Journals for Sale Mary D. Ross, Butler County Memorial Hospital, Butler, Pennsylvania: 1926: November; 1927: May through September, November; 1928: January, February, March, May, October, November, December; 1929: June, September; 1935: September; 1936: May, July, August, September, December.

Edith S. Caughron, 203 Wisconsin Street, Neodesha, Kansas, has from September 1934 to August 1935 inclusive for sale.

Miss M. J. Putnam, Box 363, Corinth, New York: March 1933 through May 1936 inclusive.

Eva J. Edwards, Granby, R.F.D., Connecticut: January 1920 through October 1933.

Mrs. Ellen Ogden, Route 2, Ponca City, Oklahoma: 1931: November; 1932: April, June through August, October through December; 1933: complete set; 1934; January through July, September, October; 1936: May, June.

Martha E. Erdmann, 430 West 118th Street, New York City: 1920: July, September through December; 1922: August, September.

Anna Schmeckel, 3509 Osage Street, St. Louis, Missouri: 1927: December; 1928: January through June; 1929: December; full set for 1930; 1932: January, February, March, June, August, September, November, December; 1934: January, June, May; 1935: February, March, April, May, September, October, December.

Eunice McConnell, 11 College Street, York, South Carolina: 1930: April through November; 1931: January; 1932: all except October and December.

NEWS ABOUT NURSING

News items should reach the *Journal* offices before the 10th of the month preceding publication.

Housing for Catholic Sisters at the Biennial Convention All Sisters planning to attend the Biennial Convention of the three national nursing organizations meeting in Kansas City, Missouri, April 24–29, may make arrangements to be housed in Roman Catholic institutions. Reservations for rooms should be sent to Elizabeth Martin, Chairman of the Housing Committee, 1,028 Baltimore Avenue, Kansas City, Missouri. Please state that a reservation for a Catholic Sister is desired. Sister Henrietta, chairman of the local committee on Catholic Sisters, will make the arrangements.

Housing for Negro Nurses Princess Alexander, Chairman of the Subcommittee on Negro Nurses, will make housing arrangements for Negro nurses who are planning to attend the Biennial Convention. Please write to Miss Alexander at 1,836 Forest Avenue, Kansas City, Missouri.

University Schools of Nursing in Missouri Nurses attending the Biennial Convention may inspect three university schools of nursing —the WASHINGTON UNIVERSITY SCHOOL OF NURSING in St. Louis, the ST. LOUIS UNIVERSITY SCHOOL OF NURSING in St. Louis, and the UNIVERSITY OF MISSOURI SCHOOL OF NURSING in Columbia.

At St. Louis University, students are accepted (beginning with the 1937–38 sessions) for a combined integrated academic and professional curriculum leading to the Bachelor of Science degree in Nursing. Certificates in nursing are conferred simultaneously with or subsequent to the achievement of the baccalaureate degree. Clinical facilities for the school are provided at St. Mary's Hospital, St. John's Hospital, and Alexian Brothers Hospital.

The school of nursing at Washington University, first organized in 1905, and reorganized in 1924, offers two courses of study: a three-year program which leads to a diploma in nursing, and a five-year program which leads to a Bachelor of Science degree as well as to a diploma. Two years basic college work is required as a prerequisite to the degree course and postgraduate courses offered in public health nursing. The clinical facilities for this school are provided at Barnes Hospital, St. Louis Children's Hospital, St. Louis Maternity Hospital, the Out-patient Clinics of Washington University, the Visiting Nurse Association of St. Louis, and other public health agencies in that city.

The University of Missouri School of Nursing, first established in 1901 in connection with Parker Memorial Hospital, was reorganized as a university school in 1920. Instruction in nursing subjects is given at Parker Memorial Hospital and Noyes Hospital. Administered as a part of the School of Medicine, the school offers a three-year combined course to high school graduates for which the student receives the degree of Graduate in Nursing and fifty hours credit toward an A.B. degree.

A Kansas City Attraction The WILLIAM ROCKHILL NELSON ART GALLERY AND MARY ATKINS MUSEUM ranks fifth among museums of the country; the gallery contains more than 5,000 objects of art from the earliest civilization of Asia Minor to the Twentieth Century. The special "period rooms" include a French Regina Salon, an English Georgian drawing room, a Spanish Italian room, and an Early American wing of five interiors

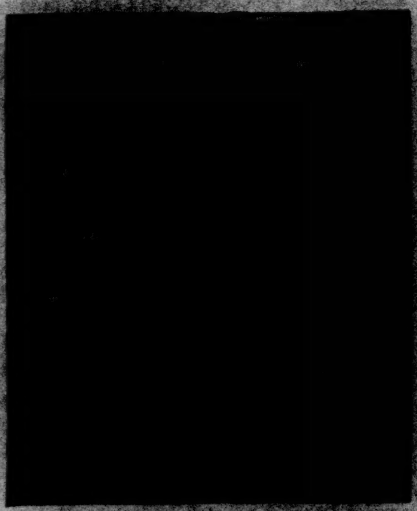
brought from various sections of the Atlantic Coast.

About People You Know

Sarah M. Bailey (Michael Reese Hospital School of Nursing, Chicago; A.B., Lander College, Greenwood, South Carolina; M.A., Columbia University, New York City), formerly director of nurses at Christ Hospital, Jersey City, New Jersey, has accepted the position of director of nurses at the New York Polyclinic Hospital, New York City.

Miss Bailey has had experience as head nurse, science instructor, and assistant to the director of nurses at Michael Reese Hospital, Chicago, and as educational director at Buffalo City Hospital, Buffalo, New York.

Kathryn Cafferty (St. Joseph's School of Nursing, St. Paul, Minnesota; B.S., Immaculate Heart College, Los Angeles), formerly instructor of nursing arts at the Queen of Angels Hospital School of Nursing, Los Angeles, has been made an inspector of schools of nursing in the California Department of Public Health. This department plans, this year, to make a careful study of the teaching of nursing arts in all the schools of nursing in the state.



Rochelle Count, William Rockhill Nelson Gallery of Art and Mary Atkins Memorial Museum, Kansas City

Miss Cafferty has had experience as supervisor and instructor in the nursing schools of Saint Vincent's Hospital, Billings, Montana, and Columbus Hospital, Great Falls, Montana, as well as Queen of Angels Hospital, Los Angeles. She has been president of the Montana State Nurses Association, secretary of the Red Cross Committee in Montana, and chairman of the Education Committee, District 5, California State Nurses Association.

Mary Reid Donald (Albany Hospital School of Nursing) has resigned as superintendent of nurses at the Albany Hospital, a position which she has filled for sixteen years. She has returned to her home in West Flamboro, Ontario.

Anna Ellerman (St. Luke's Hospital School of Nursing, Chicago) has announced her retirement from active practice, as of January 1. On that date, as announced last month, she turned over the direction of the Nurse Placement Service (Chicago) to her successor.

Upon the basis of eight years in private duty nursing, seven as an instructor, one in public health nursing, Miss Eldredge built an extraordinarily useful service to the profession and, through it, to the public at large. A mere catalog of the positions she has filled and the offices held is impressive. It has been summarized in the *Journal's* "Who's Who," July 1921, page 735 and February 1934, page 165.

Miss Eldredge's longest period in one position was the thirteen years she spent as Director of the Bureau of Nursing Education, Wisconsin State Board of Health, a position in which her gifts of leadership had full scope. Of all the encomiums heaped upon Miss Eldredge throughout her years of splendid service, we have chosen that of Dr. C.-E. A. Winslow, on the occasion of the bestowal of the Saunders Medal, (*American Journal of Nursing*, July 1935, page 849) for repetition (in part) at this time. Dr. Winslow said:

> The work of all nurses is inherently unselfish. That of the teacher who prepares the nurses is perhaps even more unselfish. The expression of selflessness is the labor of the public official who makes it easier for the teacher to educate the nurse. It is for unique distinction in this field that we honor Miss Eldredge.

HAZEL BENNETT (New York Hospital School of Nursing, New York City) formerly instructor and supervisor of the private patient nursing service of the New York Hospital, is now superintendent of nurses at the Manhattan Eye, Ear, and Throat Hospital, New York City. Miss Bennett has had experience in private duty nursing and in varied types of institutional nursing at the Fifth Avenue and New York Hospitals, both in New York City.

ANNIE W. GOODRICH, Dean Emeritus of the Yale University School of Nursing and a member of the Board of Nursing Advisors of the Neuro-Psychiatric Institute, Hartford Retreat, Hartford, Connecticut, will be in residence at the Neuro-Psychiatric Institute during the winter as consulting director.

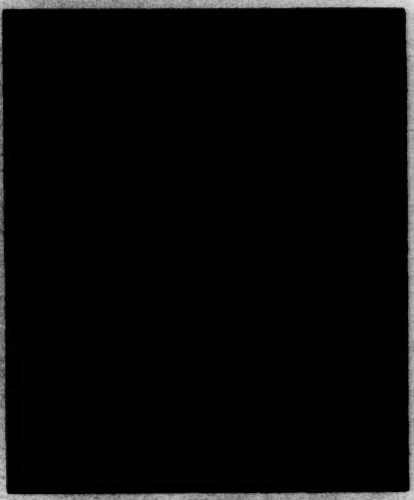
Miss Goodrich will have under advisement the general policies of the nursing service and the development of the educational work.

MARIAN G. RANDALL (Samaritan Hospital School of Nursing, Troy, New York; B.S., Columbia University, New York City) a member of the technical staff of the Milbank Memorial Fund, has accepted an appointment as supervisor of records and studies on the staff of the Henry Street Visiting Nurse Service, New York City, beginning January 1, 1938.

Previous to her appointment to the technical staff of the Milbank Memorial Fund, Miss Randall had experience in private duty nursing, in institutional nursing at the Samaritan Hospital, and at Willard School, Troy, New York, and in public health nursing with the Visiting Nurse Service, Albany, New York), the City Health Department, Amsterdam (New York), and the New York State Department of Health.

Miss Randall's recent study of *Personnel Policies in Public Health Nursing*, which was prepared for the Committee on Personnel Practices in Official Agencies for the National Organization of Public Health Nursing, is just off the press.

ELEANOR SHIELDS (Bloomingdale Hospital Nursing School, White Plains, New York, B.S., Columbia University, New York City) has recently been appointed director of the Nurses Official Directory, District 1



Harry S. Gamewell, Inc.

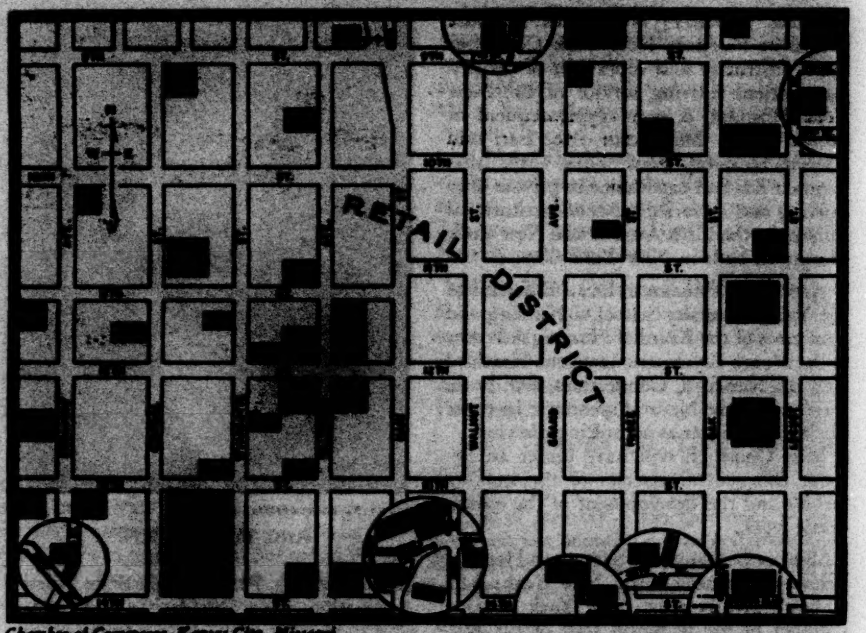
ADDA ELDREDGE, R.N.

(Philadelphia), Pennsylvania State Nurses Association. Miss Shields has had experience in nursing service and nursing education administration at her own school, at the Philadelphia General Hospital, and at the University of Iowa Psychopathic Hospital, as well as two years experience in psychiatric nursing in the private duty field. In 1932 Miss Shields returned to the Bloomingdale Hospital (now known as the New York Hospital, Westchester Division) as director of nursing, which position she held until 1937.

HELENE OLANDT (Bellevue School of Nursing, New York City; M.A., Columbia University, New York City) who since August 1937 has been director of nursing service and principal of the nursing school at Harlem Hospital, New York City, will on February 1 assume her work as directress of nurses and principal of the nursing school at St. Luke's Hospital, New York City, succeeding F. Evelyn Carling who has held this post since 1924.

Physical Examinations for Registrants

THE NURSES OFFICIAL REGISTRY OF DISTRICT 2, MISSOURI STATE NURSES ASSOCIATION (Kansas City) requires annual physical examina-



Chamber of Commerce, Kansas City, Missouri

LOCATION OF HOTELS AND POINTS OF INTEREST TO DELEGATES TO THE BIENNIAL CONVENTION, THREE NATIONAL NURSING ORGANIZATIONS, KANSAS CITY, MISSOURI, APRIL 24–29, 1938

HOTELS

For hotel addresses and room rates, see the July 1937 Journal, page 801.

18 Aladdin
32 Ambassador
21 Baltimore
38 Bellerive
14 Bray
40 Chase
9 Coates House
2 Commonwealth
22 Dixon
41 Hyde Park
13 Kansas Citian
7 Milner
17 Muehlebach
42 Park Lane Apt. Hotel
16 Phillips
33 Pickwick
43 Plaza
24 President
44 Rasbach
10 Robert E. Lee
23 Sexton
45 Snyderhof
15 Stats
46 Westgate

POINTS OF INTEREST

4 American Royal Building
8 Ararat Temple
36 City Hall
13 Convention Bureau, Chamber of Commerce
37 Court House
20 Edison Hall
29 Federal Building
27 Liberty Memorial
11 Municipal Auditorium
26 Post Office
39 Public Library
25 Union Station
12 University Club
34 Y. M. C. A.
31 Y. W. C. A.

tions of its registrants. The Jackson County Medical Society was invited to participate in evolving satisfactory examination requirements, blanks, et cetera and has appointed a committee which will meet with the Registry committee in an advisory capacity.

Hourly Nursing Service Develops

Between May 1 and December 1, 1937, the NURSING BUREAU OF MANHATTAN AND BRONX, INC., received 225 requests for hourly nursing service. All but seven of these calls were filled; 788 visits were made by the hourly nurse who is on the staff of the Bureau, and 1,309 visits were made by private duty nurses while on call for cases, making a total of 2,097 visits.

The average length of time spent on each case was one hour and twenty-six minutes. The average number of visits per patient was three. Eight per cent of the requests for hourly nursing service resulted in placing private duty nurses on a regular private duty nursing basis.

This hourly nursing service was inaugurated in April 1937, with one full-time nurse appointed on a salary basis. A second full-time nurse will be added to the staff on January 1.

District Association's Message to Members

TEXAS GRADUATE NURSES ASSOCIATION, DISTRICT 8 (San Antonio), sent 400 copies of *The American Nurses Association and You* (published by the ANA) to its members, each copy carrying a special message from the secretary-treasurer asking each one of them to secure one new member.

Norwegian Hospital Association Organized

THE NORWEGIAN HOSPITAL ASSOCIATION, an association of doctors, nurses, architects, engineers, hospital superintendents, and organizations interested in hospitals and public health (all together eleven associations) was founded November 8, 1937.

Bergljot Larsson, founder and past-president of the Norwegian Nurses Association, was elected as the first president of the new association.

Reaching Former Members

In June 1937, the ALUMNAE ASSOCIATION OF THE NEW YORK HOSPITAL SCHOOL OF NURSING adopted a waiver in honor of the sixtieth anniversary of the school in an effort to bring back into membership some of its former members. Under the waiver, all members who had been dropped for non-payment of dues were given the opportunity to be reinstated upon payment of dues for the current year, and were extended a cordial invitation to attend the meetings of the association.

The waiver was extended to December 31 and proved to be an excellent way of reaching former members. On December 1, thirty-three former members had been reinstated and many other applications for reinstatement were under consideration.

This attractive seal is the official emblem of the FLORIDA STATE NURSES ASSOCIATION which was adopted some time ago. It is used on all stationery, programs, bulletins, and other publications issued from time to time from the offices of the association.

A Unit of Advanced Maternity Nursing

MATERNITY CENTER ASSOCIATION, NEW YORK CITY, in cooperation with the Department of Nursing Education of Teachers College, announces that it will conduct a two months' program of advanced maternity nursing for a limited number of maternity supervisors in the field of public health nursing.

The course offers lectures on obstetrics, community maternity nursing, and other subjects affecting the care of maternity patients; supervised field observation, round table discussion of administrative and other problems, assigned reading, and study hours will be included.

Nurses wishing to register should write directly to the Maternity Center Association, 1 East 57th Street, New York City, before January 20, giving name, address, and position held.

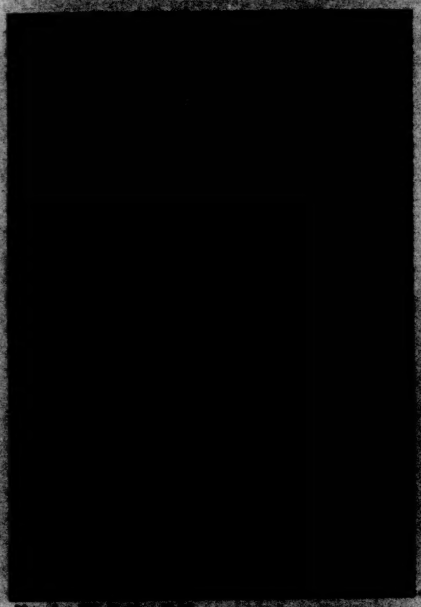
This unit should not be confused with the four-months and eight-months courses

in advanced maternity nursing offered regularly by Teachers College in conjunction with the Maternity Center Association.

State Board Examinations Ninety per cent of the graduates of Colorado nursing schools who wrote the state board examination in November (1937) were successful. Since there has been no change in the standards of the examination, it seems evident that candidates taking the examinations are better prepared than in former years. There has been a marked increase in the number of candidates applying for registration by reciprocity.

In California, nineteen schools of nursing had students with no failures in the November examination. There was an unusually large percentage of candidates who were "repeaters" and candidates from out-of-state schools.

Of the students taking the state board examination in Wisconsin in October (1937), 22.8 per cent made a grade of A in communicable disease nursing; 12.6 per cent made a grade of A in nursing arts; 11.3 per cent made a grade of A in professional problems; only 1 per cent made a grade of A in medical nursing.



Eli White Memorial, Nurses Residence, St. Luke's Hospital, New York City

Another New Nurses Residence The Eli White Memorial, the nurses residence of St. Luke's Hospital, New York City, dedicated on December 16, 1937, has a capacity of 305 rooms for students, graduate staff, and faculty.

The entrance is flanked by small reception rooms, with offices and a panelled library on one side. Extending across the back of the building is a large auditorium with a stage, dressing rooms, balcony, and motion picture projection room. On the main floor there is a pantry for serving refreshments.

The upper floors have a completely equipped nine-room infirmary, a soundproof gymnasium and gameroom, single rooms for student and graduate nurses, and terraces which overlook the city and provide a view of both rivers. On each floor nurses will have the use of a kitchenette and a laundry.

Classrooms, a laboratory and dietetic department, and a library are located on the third floor; the student and graduate dining-rooms and the kitchen on the second floor.

Manelva Keller, an alumna of the school and clinical photographer in the hospital made the photograph of the new residence which appears on this page.

Eight-hour Schedule in Kentucky On December 1, 1937, the eight-hour schedule was put into effect at St. Joseph's Hospital, Lexington, Kentucky. This not only affects the private duty nurses, but also the general duty nurses on the staff of the hospital.

On January 1, 1938, the Mason Memorial Hospital, Paris, Kentucky, will inaugurate the eight-hour day for private duty nurses.

Nursing Care Begins At Home Members of the Methodist Hospital (Dallas, Texas) School of Nursing Alumnae Association rendered forty-two (eight-hour) days of nursing care to ill student nurses in the Methodist Hos-

pital and thirty-eight (eight-hour) days of service to graduate nurses who were ill during the year 1937.

The total number of eighty days of gratuitous nursing service rendered by the association is equivalent to the sum of $400.

The Alumnae Association boasts 100 per cent membership of the graduates of the school.

Nurses' Library Service in Georgia

The Georgia State Nurses Association has issued a classified list of books, bulletins, magazines, pamphlets, and reprints that are available to its members from the library and nursing information bureau at its headquarters in Atlanta.

Books may be kept three weeks by out-of-town members, except seven-day books and magazines. Nurses residing in Atlanta may keep books two weeks, except seven-day books and magazines. A fine of five cents a day is charged for all books kept overtime. The borrower is held responsible for all books and for all fines accruing. Where mailing is necessary, postage from library and return is paid by the borrower. All injuries to books beyond reasonable wear and all losses are to be made good to the satisfaction of library personnel.

Nurses are urged to use the library for reference reading. The chairman of the public information committee offers her services to nurses who wish help in securing books or information. Each district association has been requested to submit a list of books and magazines that they would like to have placed in the state association library.

Community Nursing Surveys Made

Community nursing surveys have been made by the Joint Committee on Community Nursing Service (of the three national groups in nursing) in four communities during the last three months. The surveys were conducted by Lulu St. Clair, Executive secretary of the Committee, in Duluth and in Blue Earth County, Minnesota, under the sponsorship of the Minnesota Nurses Association; in Saginaw, Michigan, under the sponsorship of the Saginaw Council of Community Nursing Service; and in Battle Creek, Michigan, under the sponsorship of District 4, Michigan State Nurses Association.

Fiftieth Anniversary Celebrated

Lenox Hill Hospital School of Nursing, New York City, celebrated its fiftieth anniversary by a four-day program, November 16–19, 1937. Two former superintendents of nurses, Charlotte Ehrlicher (1898–1910) and Elizabeth P. Lindheimer (1913–1935), and Mrs. Pauline Damstadt Rehling (class of 1888), the only surviving member of the first class to graduate, were guests of honor at the 1937 commencement exercises. The Achelis Scholarship, awarded annually to a member of the graduating class for further study in the Department of Nursing Education at Teachers College, Columbia University, was presented to M. Regina Woods.

Other programs of the anniversary week included trips through the nurses residence, and classrooms, the hospital and dispensary, and symposia and demonstrations of the nursing care of the patient suffering from pneumonia, the administration of oxygen, sputum typing, the nursing care of the patient with tuberculosis, and pneumothorax treatment.

Other events were a recital by the nurses' glee club, a students' hobby show, teas, receptions, and a supper dance under the auspices of the Alumnae Association.

Nursing Scholarships in Albania

Mlle Bullati, an Albanian Red Cross Nurse, has recently completed three years of supplementary study at the nursing school of the Yugoslav Red Cross in Beograd. This study was made possible through a scholarship awarded by the International League of Red Cross Societies. Mlle Bullati is now following an additional course of six months in the school for public health nurses at Zagreb, Yugoslavia, with the aid of a scholarship granted by the Albanian government.

Nursing School Mothers' Club

The Mothers' Club of Toledo Hospital School of Nursing, was formerly organized about two years ago to help the mothers of student nurses understand some of the problems of nursing education,

and to disseminate information to the general public through them.

The members have studied various phases of nursing education as they affect individual nurses and the public. They have raised funds to buy coats for the nurses who are having experience in public health nursing, and have shared with the nursing school the expense of providing speakers on mental hygiene, social hygiene, et cetera. The organization has proved to be a valuable auxiliary in promoting nursing education and in establishing wider relationships with other groups in the community.

New York School Discontinued

The last three students to complete their nursing course at the Jamaica Hospital School of Nursing, Jamaica, Long Island, received their diplomas in September, 1937. The school has been discontinued and the hospital is now staffed with graduate nurses.

Geography of Nursing News

The news section of the *Journal* carried 991 items about nursing and nurses during 1937. New York state which has the largest state association membership was the largest contributor, with 94 items to its credit. (This does *not* include the items about the national nursing organizations.) California and Illinois come next with 31 items each; Massachusetts had 28; Pennsylvania 26; Texas and Wisconsin, 25 each; Minnesota 23; Michigan and Missouri, 22 each; the rest of the states ranged from 19 to 1.

Comparing the number of news items and the membership of the state associations, however, we find that the states reporting the most news per member were: Wyoming which contributed 1 item to every 55 members; New Mexico and Vermont, 1 item to 59 members; Arkansas, 1 item to 78 members; Idaho, 1 item to 83 members; Montana, 1 item to 97 members; Oklahoma, 1 item to 105 members; Arizona, 1 item to 107 members; Wisconsin, 1 item to 109 members; Mississippi, 1 item to 111 members; Rhode Island, 1 item to 115 members; Delaware, 1 item to 123 members.

Recent Meetings

Arizona State Nurses Association, October 21–23, 1937, Tucson. A replica, in Arizona copper, of the lamp of Florence Nightingale was displayed at the opening session of the meetings. The lamp, presented by Beverly F. Burke, was awarded (at the closing session) to District 3, the district association showing the greatest percentage of increased enrolment since the last state convention.

Speakers and subjects at the meetings included: Dr. Roland Davison, president of the Pima County Medical Society, "Recent Advances in the Practices of Medicine"; Miss Lucille Moore who reported her trip to London to attend the Congress of the International Council of Nurses; Mrs. Marjorie Bruning, "In Pursuit of Learning"; Sister Ann Raphael, "Child Health Through School Adjustment."

Papers and demonstrations on clinical subjects included: "Artificial Fever Therapy" by Dr. William G. Schultz; "Infantile Paralysis and the Respirator" by Dr. B. P. Storts, Jr.; "Mental Hygiene" by Dr. O. A. Simley; a demonstration of the oxygen tent and the Wangensteen apparatus by Dr. Delbert Secrist; and a paper on "Vomiting" by Mrs. Manette Mealins.

At the Public Health Nursing Section, Florence Stein served as chairman in a panel discussion of "The Rôle of the Public Health Nurse in the Control of Syphilis."

An interesting pageant depicting the evolution of the nurse's uniform was presented to two hundred and ten nurses attending the Private Duty Nursing Section luncheon.

Officers of the State Association for the coming year are: President: Mrs. Bertha G. Easton, Phoenix; Vice-president: Mrs. Margaret M. Smith, Globe; Secretary: Minnie C. Benson, Tucson; Treasurer: Catherine Beagin, Miami; Directors: Mrs. Regina Hardy, Mrs. Emma Ruth Dise, and Mrs. Elizabeth Steelsmith.

Public Health Nursing Section: Chairman: Mrs. Mary Katherine Vivian, Phoenix; Secretary: Julia Kelly, Phoenix.

Private Duty Nursing Section: Chairman: Gayl W. Mowitt, Phoenix; Secretary: Mrs. Frances George, Tucson.

KANSAS LEAGUE OF NURSING EDUCATION held its annual convention October 26–30, 1937, in Topeka.

The following officers were elected: Vice-president: Sister Lena Mae Smith, Newton; Secretary: Alicia Sayre, Kansas City; Director: Sister M. Gonzaga, Wichita.

The other officers remaining from 1936 to 1938 are: President: Ethel Templin, Salina; Treasurer: Minnie Cox, McPherson; Directors: W. Pearl Martin, Manhattan; Anna Louise Wayne, Kansas City.

The next annual meeting will be held in Hutchinson.

LOUISIANA STATE NURSES ASSOCIATION, LOUISIANA LEAGUE OF NURSING EDUCATION, November 22–24, 1937, St. Charles Hotel, New Orleans.

At the joint opening session, Ella Best, Associate Director of American Nurses Association Headquarters, spoke on "Nursing, a Service and a Profession." At a later session, Isabel M. Stewart, Teachers College, Columbia University, outlined the League's plans for gradually but steadily forging ahead in putting nursing education on a professional level.

At the Public Health Nursing Section session, there was a discussion of "What Public Health Nursing Organizations Have Done in the Past, What They Are Doing Now, and What They Will Do in the Future."

Private duty nurses held a round-table discussion on the "Eight-hour Day." Miss Best offered some very helpful suggestions regarding promotion programs.

At the annual banquet, the silver jubilee of state registration in Louisiana was celebrated. Members of the Louisiana Nurses Board of Examiners, Barbara Frank, and the late Emma Wall, all of whom were instrumental in having the nurse registration law passed, were specially honored.

Officers for the State Association for 1938 are: President: Edith Faris, Monroe; Vice-president: Anna M. Barr, Monroe; Secretary: Jane E. Martin, New Orleans; Treasurer: Lora C. Golden, Baton Rouge; Directors: Ina E. Spillers, Lake Charles; Cornelia Gravel, Alexandria; M. A. Price, New Orleans.

Officers elected for the State League for the coming year are: President: Marion Zilley, New Orleans; Secretary-treasurer: Elizabeth Rowe, New Orleans; Directors: Sister Celestine, Anita I. Discon, both of New Orleans.

MARYLAND STATE NURSES ASSOCIATION, MARYLAND LEAGUE OF NURSING EDUCATION, MARYLAND STATE ORGANIZATION FOR PUBLIC HEALTH NURSING, November 16–18, 1937, Baltimore.

"Uniformity in Nursing Procedures" was the general topic of discussion throughout the meetings.

Mrs. E. H. McBride, a member of the State Board of Nurse Examiners, and Sister Mary Helen, Secretary of the Board, discussed the function of the educational adviser of the state board of nurse examiners in securing uniformity in the practice of bedside nursing.

"Legislation as It Affects Nurses" was discussed by the chairman of the state legislative committee, Annie Crighton. Helen S. Dunn, Assistant Director, American Red Cross Nursing Service, spoke on Red Cross membership.

At the Private Duty Nursing Section, Dr. J. Arthur York spoke on "New Developments in Anesthesia" and Dr. Charles Bagley, Jr., on "Surgical Treatment of Hypertension."

At the joint session, under the auspices of the State Organization for Public Health Nursing, Mr. James E. Hancock gave an interesting talk on "Old Baltimore" and at the joint session under the auspices of the State League of Nursing Education, M. Louise Synder, Education Adviser, Pennsylvania State Board of Examiners for Registration of Nurses, discussed her work; Claribel Wheeler, Executive Secretary, National League of Nursing Education, discussed the suggested plan for accrediting schools of nursing and interpreted the objectives of the National League of Nursing Education.

Demonstrations were presented by the student nurses affiliated with the Eastern and Western Health Districts at the rural public health nurses meeting, and demonstrations of comparative nursing procedures were given at a State League session. A

large group of nurses visited the Baltimore City Hospitals.

Elsie M. Lawler, Superintendent of Nurses, Johns Hopkins Hospital, Baltimore, gave a delightful report of the International Congress from both the professional and social viewpoints at the dinner which closed the meeting.

The annual meeting of the three state nursing organizations will be held January 20, Osler Hall, Baltimore.

New Hampshire State Graduate Nurses Association, quarterly meeting, December 8, 1937, Concord.

Ruth Sleeper, Massachusetts General Hospital School of Nursing, spoke at two sessions on the *Curriculum Guide* in relation to its adoption and adaptation in nursing schools.

Thelma Pratt and Mrs. John Hayes reported their investigation of the feasibility of establishing courses in nursing and allied subjects for both graduate and student nurses at the State University. It is hoped that several nursing courses will be initiated next year.

Dorothy M. Breene, Director of Nursing Education, New Hampshire State Hospital, was chosen chairman of a committee to arrange an institute which will be held in the spring.

The Private Duty Nursing Section attended a demonstration of treatment in an oxygen tent at the Margaret Pillsbury Hospital.

The Public Health Nursing Section was addressed by Mrs. Gage Rogers, Director of Crippled Children's Camp, who discussed "The Spastic Child."

Two hundred members attended the general session at which Carrie M. Hall discussed "The Harmon Insurance Plan for Nurses." Movies incident to her subject were shown. Dora M. Cornelisen, Field Representative of the *Journal*, also spoke at this session. Mrs. Eva F. Crosby reported her attendance at the Congress of the International Council of Nurses in London last July.

Mrs. Lois Barton of Plymouth, was appointed *Journal* representative for New Hampshire.

Officers of the League for the coming year are: President: Sister Mary Larrivee, Manchester; Vice-president: Margery MacLachlan, Concord; Secretary: Thelma A. Pratt, Concord; Treasurer: Mary H. Griggs, Concord; Directors: Ellen Young, Nashua; Alexandria Moleske, Hanover.

Pennsylvania State Nurses Association recently conducted two district institutes in cooperation with the Pennsylvania Tuberculosis Society.

At the first institute held in the Presbyterian Church in DuBois, October 9, the speakers were Dr. Harold T. Brown and Alice Stewart, both of the Tuberculosis League of Pittsburgh.

The speakers at the other institute held at Hotel Easton in Easton, October 14, were Dr. H. W. Hetherington and Fannie Eshleman, both of the Henry Phipps Institute. More than one hundred persons attended the morning and afternoon sessions. In the group were doctors, laymen, the chairman of the school board, a school superintendent, principals of high and junior high schools, school doctors and nurses, representatives from parent-teacher groups, and nurses and doctors from industrial plants.

The luncheon address, given by Dr. R. H. McCutcheon, Bethlehem, on "What a Layman Needs to Know About Tuberculosis" was broadcast over the local radio station.

Pennsylvania State Nurses Association, District 4, York Hospital, York, held an institute on cancer at its November (1937) meeting. Dr. Stanley P. Reimann, Director of the Research Institute, Lankenau Hospital, Philadelphia, spoke on promoting cancer research efforts through an educational campaign. Dr. Reimann urged nurses to take advantage of the opportunities to assist in a program for cancer control by teaching people to seek early and prompt medical attention for all ailments.

Mary A. Rothrock, Superintendent and Director of Nursing, Clearfield Hospital, Clearfield, spoke on the nurse's rôle in cancer control.

Texas Graduate Nurses Association. Between October 25 and November 23, 1937, the general secretary of the Texas Graduate Nurses Association conducted one-day in-

stitutes in the district associations in the following cities: Tyler, Fort Worth, Dallas, Austin, San Antonio, Brownsville, Sherman, and El Paso. One institute for the colored nurses of Dallas, Forth Worth, Denison, Tyler, and other places was held in Dallas.

A total of 728 nurses attended the institutes, at which fifty-one addresses were given and nineteen private conferences were held.

Subjects relating to the opportunities and responsibilities of officers and members of the state and local nurses associations were discussed at each institute. Some of the clinical subjects presented under the auspices of the district associations were: a demonstration of new equipment for blood transfusion, a demonstration of the Drinker respirator and a discussion of the care of the patient in a respirator, the functions and aims of the International Council of Nurses, the National League of Nursing Education, and the National Organization for Public Health Nursing.

Most of the programs included social functions. This is the first time that the district associations have shared in the preparation and presentation of institutes sponsored by the Texas Graduate Nurses Association.

Graduate Nurses Association of Virginia, Educational Section, Institute of Nursing Education, November 22–23, 1937, Academy of Medicine, Richmond.

The institute was financed partly by a registration fee ($1.00 for all sessions, fifty cents for one session) and partly with funds appropriated for the activities of the Educational Section of the State Association. Sixty-one students and ten guests who attended the institute were not charged a registration fee. The total registration was 168; seventy-five attended all sessions.

Nellie X. Hawkinson, Professor of Nursing Education at the University of Chicago, and President of the National League of Nursing Education, speaking at the first session of the institute, outlined the factors to be considered in the adaptation of the new *Curriculum Guide* to the needs of the individual nursing school.

In discussing this paper, Josephine S. McLeod, Inspector of Schools of Nursing in Virginia, said that the nurses in Virginia have been preparing for an improved educational program throughout the past twenty-five years. Emphasis has been placed on the upgrading of faculty members; many schools have long had a six-months preliminary period, and have found that this is most advantageous; the directors of the school have tried to make the best possible selection of students. She said, "We are all trying to give the best preparation to nurses in order that their services to our patients may be better."

Dr. Lewis E. Jarrett, Superintendent of the Hospital Division, Medical College of Virginia, discussing Miss Hawkinson's paper from the viewpoint of the hospital administrator, outlined the reasons for the hospital administrator's interest in the nursing school curriculum. He felt that there must be a close coöperation between all groups affected by changes in nursing education in order that the needs of the community may be properly supplied.

"The Florence Nightingale International Foundation Course—Its Scope and Opportunities," was discussed by Lulu K. Wolf, Associate Professor of Nursing, Medical College of Virginia, who was the recipient of one of the scholarships provided by the ANA from funds raised for the Florence Nightingale International Foundation. Miss Wolf felt that the values of such a course could be summarized as: expanded horizons, an international viewpoint, increased tolerance, and a deeper understanding of human nature.

Mary J. Dunn, Regional Public Health Consultant, United States Public Health Service, speaking on "The Nurse—A Community Worker," pointed out that the nurse, in order to be most useful to the community, should possess a fundamental working knowledge of health nursing as well as of nursing the ill, she should be essentially a health teacher, and she should be concerned with the social conditions which directly affect the condition and the recovery of the patient.

Mrs. Dorothy Albright, Educational Director, Instructive Visiting Nurses Association, Richmond, discussing this paper, stressed the need for more simplified nurs-

ing technics and procedures within the nursing schools. Both Miss Dunn and Mrs. Albright suggested that it would be well to have a public health nurse on the nursing school faculty to assist in outlining or revising nursing procedures and technics.

"The Rôle of the Nurse in the Program of Gonorrhea and Syphilis Control" was discussed by Dr. Otis Anderson, Director, Division of Venereal Disease, Virginia State Department of Health. Following his address, he showed the talking picture "For All Our Sakes."

West Virginia State Nurses Association, October 21–23, Martinsburg. At the community meeting (which is held each year) Dr. M. V. Ziegler, Assistant Surgeon General, U. S. Public Health Service, spoke on "Increasing Responsibilities of the Nursing Profession." He pointed out that it is quite imperative that the nurse's preparation be commensurate with the function she is to perform, and that the improvement of the quality of nursing service and the better preparation of the nurse is the responsibility of all branches if nurses are to render better service to mankind.

Mary M. Roberts, Editor of the *American Journal of Nursing*, spoke on "A Flexible Pattern for Private Duty Nursing"; Teresa Rutledge, New York City, discussed "Nursing—Science or Art." Mrs. B. E. Sutton, Chairman, Private Duty Nursing Section, presided at this meeting. Dr. Frank Slutz, Dayton, Ohio, presented three addresses entitled: "Are You a Problem Adult?"; "What Price Personality?"; "The Art of Living Together."

Dr. Edward F. Reaser, Huntington State Hospital, made a plea for a better understanding of the child's mind and emotions.

The address given by Mrs. Francia B. Crocker, National Society for the Prevention of Blindness, at the Public Health Nursing Section on sight conservation, was very helpful and suggestive.

Ida F. Butler, Director of Nursing, American Red Cross, speaking at a luncheon meeting and at a students' meeting, challenged nurses to answer the call for first reserves in the Red Cross nursing service. Ohio Valley General Hospital, Wheeling, won the banner for 1937 by having the largest enrolment of Red Cross nurses during the year.

Myrtle M. Hollo, Assistant Professor of Nursing Education, University of Virginia, contributed to the discussions at the Educational Section round tables. At a general session, she spoke on "The Nurse as a Teacher." Ruth Heintzelman, Nursing Consultant from the Federal Children's Bureau, conducted the Public Health Nursing Section round table discussions of the program for maternal care in rural areas.

Blanche Young of Martinsburg was narrator at a pageant depicting the early history of nursing.

The sessions for student nurses were well-attended this year; nearly every school of nursing in West Virginia sent one or more students. A demonstration of oxygen therapy in upper respiratory infections was given at one of the meetings.

District 1 (Wheeling) won the award for having the largest membership this year.

Officers elected for the coming year are: President: Ora Campion, Elkins; Vice-president: Harriette Drain, Clarksburg; Secretary-treasurer: Pansy Jacobs, Fairmont.

Coming Meetings

Maryland State Nurses Association, Maryland League of Nursing Education, Maryland State Organization for Public Health Nursing annual meeting, January 20, Osler Hall, 1211 Cathedral Street, Baltimore.

Utah State Nurses Association, February (day not set), Hotel Newhouse, Salt Lake City.

Special Funds

Florence Nightingale International Foundation

Send contributions to the American Nurses Association, 50 W. 50th St., New York City. Checks should be made out to that organization. Information may be obtained from the chairman of the American Nurses Association Committee on the Florence Nightingale International Foundation, Mary M. Roberts, 50 West 50th Street, New York City.

November 1937

Contributions

Massachusetts: New England Deaconess Alumnae	$ 5.00
Minnesota: State Association	25.00
New Jersey: Newark Beth Israel Alumnae	15.00
Total	$ 45.00

THE ISABEL H. ROBB MEMORIAL FUND

All correspondence regarding the Robb and McIsaac Funds should be addressed to Mrs. Mary C. Eden, Secretary-Treasurer, 43rd and Locust Sts., Philadelphia, Pa.

November 1937

Contributions

District of Columbia: Graduate Nurses Association	$ 25.00
Indiana: State Association	10.00
Massachusetts: Memorial Alumnae Association, Worcester	10.00
New England Deaconess Alumnae Association, Boston	5.00
Mississippi: State Association	5.00
Missouri: State Association	50.00
Oklahoma: State Association	10.00
Pennsylvania: Presbyterian Alumnae, Philadelphia	25.00
West Virginia: State Association	10.00
Total contributions	$150.00
Interest on investments	110.00
Total receipts	$260.00

MARY C. EDEN
Secretary-treasurer

THE MCISAAC LOAN FUND

Receipts

District of Columbia: Graduate Nurses Association	$ 25.00
Indiana: State Association	10.00
Massachusetts: Memorial Alumnae Association, Worcester	10.00
New England Deaconess Alumnae Association, Boston	5.00
Mississippi: State Association	5.00
Missouri: State Association	50.00
New Jersey: Beth Israel Alumnae Association, Newark	10.00
Oklahoma: State Association	10.00
Pennsylvania: Presbyterian Alumnae, Philadelphia	25.00
West Virginia: State Association	10.00
Total contributions	$160.00
Partial payments on loans	336.00
Total receipts	$496.00

Disbursements

One loan granted	$200.00

MARY C. EDEN
Secretary-treasurer

GOVERNMENT NURSING SERVICES

ARMY NURSE CORPS

Appointments: Nine: To Fort Banks, Mass., Dorothy M. Leonard; Beaumont General Hospital, El Paso, Texas, Betty Nichols; to Letterman General Hospital, San Francisco, Calif., Harriett E. McIlroy; to Maxwell Field, Montgomery, Ala., Mary Josephine Oberst, Edith M. Reed; to Fort Sam Houston, Texas, Edna Mae Aycock; to Fort Sill, Okla., Bertha E. Lantz; to Walter Reed General Hospital, Army Medical Center, Washington, D. C., Mildred Cowan and Madelle Drennan.

Transfers: To William Beaumont General Hospital, El Paso, Texas, Helen Adams, Elizabeth B. Mahoney; to Fort Jay, New York, Mabel E. Hause, Elizabeth Barker; to Letterman General Hospital, San Francisco, Calif., Rebecca Carlton; to Maxwell Field, Montgomery, Ala., Zita Callaghan, Chief Nurse; to Fort Sam Houston, M. Arlene Swanson, Della W. Ward; to West Point, N. Y., Dora A. Noble; to the Hawaiian Department, Margaret L. Burgess, Vera A. Lawton, Clarice D. Marsden; to the Philippine Department, Rosalie D. Colhoun, Catherine C. Myers.

Appointments revoked: Madeline S. Doherty to Fort Monmouth, N. J.

Discharged: Jessie Brownson, Vera Grier, Kathleen Guthrie, Deltha E. Haach. Elizabeth S. White.

Retired: Olive C. Blazey.

JULIA O. FLIKKE
Major, Army Nurse Corps
Superintendent

NAVY NURSE CORPS

New appointments: Three.

Transfers: To Annapolis, Helen C. Gorzelanski; to Canacao, P. I., Ida M. Ildstad, Ruby Lenoire Smith; to Guam, M. I., Edna O. Morrow, Dorothy L. Krell; to Mare Island, Calif., Zoe H. O'Connell, Hazel Bullard; to Newport, R. I., Mabel Franana; to New York, N. Y., Lillie M. Anderson; to Quantico, Va., Arietta M. Davis; to San Diego, Calif., Marian B. Olds, Grace B. Lally, Chief Nurse, Teresa M. Duggan; to Course in Anesthesia, Long Island College Hospital, Brooklyn, N. Y., Reba Sanders.

Separations: Blanche A. Cihak, Lois Hauser, Doris A. Samson.

Retired: Lilla H. Sawin.

Myn M. Hoffman
Superintendent

U. S. PUBLIC HEALTH SERVICE

New appointments: Ten: To Buffalo, N. Y., Elma Clara Belscher; to Cleveland, O., Frances P. Costello; to Detroit, Mich., Dorothy Murray, Francetta Peters; to Mobile, Ala., Juanita Robertson; to New Orleans, La., Audrey M. Clark, Jo Bet Alexander; to San Francisco, Calif., Beryl Nance, Cora Butler; to Stapleton, N. Y., Mrs. Edna N. Beal.

Transfers: To Detroit, Mich., Laura T. Stinnette; to Baltimore, Md., Lucille R. Denton; to Boston, Mass., Mrs. Ruth T. Johnson; to Mobile, Ala., Viola M. Chauvin; to St. Louis, Mo., Mary H. DeGuire; to Galveston, Tex., Willie Wagner.

Retired: Josephine Cooper.

Katharine S. Read
Superintendent of Nurses

U. S. VETERANS ADMINISTRATION

New appointments: Fifty-five.

Resignations: Twenty-six.

Transfers: Twenty-eight: To Lyons, N. J., Margaret Hippey, Louise Caillouet, Helen Riordan; to Castle Point, N. Y., Margaret McCarthy, Maude A. Denne, Marie Ellicker; to Alexandria, La., Gladys Ballenger; to Des Moines, Ia., Myrtle Thompson; to Huntington, W. Va., Catherine Fahey; to Muskogee, Okla., Gleola Howard; to Sunmount, N. Y., Grace Lowry, Florence Gigler, Katherine Bohan; to Rutland Hgts., Mass., Irene Rober; to Coatesville, Pa., Lena Kaufman; to Legion, Tex., Margaret Combs, Frances McClellan; to Tucson, Ariz., Mildred L. Waller, Ruth Hodges; to Columbia, S. C., Abbie London, Camila Porcher, Thelma Waters, Pearl Doyle; to Danville, Ill., Belle Tappins; to Los Angeles, Calif., Edwina Shelton; to San Fernando, Calif., Carla Lundy; to San Francisco, Calif., Sadee Jensen; to Palo Alto, Calif., Ethel Lloyd.

Retired: Rose Vaughn, Mabel Miller.

Mary A. Hickey
Superintendent of Nurses

U. S. INDIAN SERVICE

Appointments: Four.

Separations: Five.

Transfers: Eleven: To the Hoopa Valley Agency, Calif., Rubye Barry; to the Shawnee Sanatorium, Okla., Sallie Brittain; to the Five Civilized Tribes Agency, Oklahoma, Gertrude F. Hosmer; to the Rosebud Agency, S. D., Mrs. Ollie M. Bosch; to the Tacoma Hospital, Wash., Ruth E. Burr; to the Indian Service at Large, Carlotta A. Vann; to the Northern Idaho Agency, Idaho, Mrs. Margaret Rhodd Agnew; to the Fort Apache Agency, Ariz., Margaret Marie McGill; to the Navajo Agency, Arizona and New Mexico, Dorcas A. Hall; to the Warm Springs Agency, Oregon, Erma Hamrick; to the Osage Agency, Okla., Mrs. Esther F. Martin.

Elinor D. Gribo
Director of Nursing

STATE BOARD EXAMINATIONS

NEBRASKA: February 15–17, Lincoln and Omaha. File applications before February 1 with Carol L. Martin, Director, Bureau of Education and Registration for Nurses, State Capitol, Lincoln.

WISCONSIN: March 29–April 1, Milwaukee. File applications by March 9 with Barbara A. Thompson, Director, Bureau of Nursing Education, State Board of Health, Madison.

OBITUARIES

Mary C. Burtz (class of 1917, Lancaster General Hospital School of Nursing, Lancaster, Pennsylvania) on November 12 at Rossmere, Pennsylvania, of a cerebral hemorrhage. Miss Burtz served at the Lancaster General Hospital for nine years as supervisor in the maternity and children's wards, later doing some private duty nursing in Lancaster. At the time of her death and for nine years prior to it she was employed as industrial nurse by the Stehli Silk Corporation at Rossemere, Pennsylvania. She was an active member of her alumnae association, having served one term as its president.

Rose L. Day (class of 1895, St. Luke's Hospital School of Nursing, Newburgh, New York) on October 26 at her home after a short illness. Miss Day was the first graduate of St. Luke's and the greater part of her nursing life had been spent in the private duty field.

Margaret M. Donegan (class of 1932, Coatesville Hospital School of Nursing, Coatesville, Pennsylvania) in November at Mount Kip, Glen Garden, New Jersey, of tuberculosis. Before her illness Miss Donegan was an operating room nurse at the Coatesville Hospital and at the Paul Kimball Hospital, Lakewood, New Jersey.

Mattie Gast (class of 1910, Lancaster General Hospital School of Nursing, Lancaster, Pennsylvania) on October 22 at Beach Borough Hospital, Point Pleasant, New Jersey, of a heart attack. Several years ago Miss Gast served as night superintendent of the Lancaster General Hospital for a period of years.

Nancy Haight (class of 1887, Farrand Training School for Nurses, Harper Hospital, Detroit, Michigan) on December 3 in San Diego, California. For sixteen years following graduation Miss Haight served as supervisor at the Harper Hospital, Detroit. She served also as superintendent of the Children's Hospital of Michigan in Detroit; and as superintendent of the Home for Crippled Children in Chicago for six years. She was the first nurse in charge of Rest Haven Home for Tubercular Children at Los Angeles. Her last position, held six years, was that of night supervisor of the Mission Hospital, Huntington Park, California, from which she retired eight years ago.

Harriett Pearson (class of 1907, Baroness Erlanger Hospital School of Nursing, Chattanooga, Tennessee) on October 29 in Chattanooga, Tennessee, as the result of a heart condition. Immediately after graduation she accepted a position on the nursing staff of the Baroness Erlanger Hospital and on December 1, 1914, was made superintendent of the hospital and continued in that position until 1935 when she resigned because of ill health. Her life has been one of inspiration and service in her quiet, unassuming way. Hundreds of doctors and nurses will remember her as a friend who helped them over rocky roads in their early careers.

Mary C. Shandor (class of 1912, Lancaster General Hospital School of Nursing, Lancaster, Pennsylvania) in May 1937 at Iron Mountain, Michigan, of carcinoma of the stomach. Miss Shandor, aside from a brief period in the Children's Hospital, Detroit, Michigan, was a private duty nurse in Iron Mountain, Michigan, until 1924, when poor health forced her to retire from active practice in nursing.

BOOKS ON PROFESSIONAL SUBJECTS

L'Infirmière Hospitalière: Guide Théorique et Pratique de L'École Florence Nightingale de Bordeaux. Tome I.—Médecine. 286 pages. Illustrated. J. B. Baillière et Fils, Paris, France. 1938. Price, 32 francs for this volume; $3.25 for the two volumes.

Although only the first of the two volumes, that on medical nursing, is available at this time, it may be convenient for those desiring the books to order the two at one time.

These French texts on nursing procedure are of especial interest, since they were written at the Bordeaux School. It is believed they will be of value not only to the home school but throughout France and wherever French is easily read. Mlle Cornet-Auquier, the present superintendent of the school and hospital, and Mlle Bruckmann, the educational director of the school, have utilized materials gleaned on visits to this country to supplement the notes previously collected for the use of her students by Dr. Anna Hamilton and used for classwork in the school.

The American Committee on the Bordeaux School assisted with the work by providing a sum of money to be used for illustrations, thus greatly enhancing the interest and value of the books.

The work should have a place in many of the libraries of schools of nursing in this country, both because it originated in the American Nurses' Memorial and because it reflects certain developments in French nursing.

A prefatory tribute to American nurses and the introductory section devoted to the international and national organizations of nursing (in France) add to the interest of the first volume.

Journal readers may find it convenient to place orders through Evelyn Walker, Secretary of the Advisory Committee, whose address is 131 Pearl Street, Red Bank, New Jersey.

Textbook of Surgical Nursing. By Henry S. Brookes, Jr., M. D. 636 pages. Illustrated. C. V. Mosby Company, St. Louis. 1937. Price, $3.50.

Reviewed by Phyllis M. Young, R.N., Head Floor Nurse, Surgical Division, Presbyterian Hospital, New York City.

This new textbook is a work of extraordinary scope. Not only does it cover, in addition to the field of general surgery, the specialties—eye, ear, nose and throat, urology, gynecology, orthopedics and neurology—but also the less common conditions in these fields and the more recent advances in surgery so often omitted from textbooks for nurses. Throughout, it is abundantly illustrated.

There is a wealth of information in this book. Three chapters are devoted to the organization and equipment of the operating room, the preparation and handling of sterile supplies, and the principles of sterile technic. From beginning to end, the text is excellent in its definitions of pathological conditions and in its description of operative procedures.

Dr. Brookes believes that a nurse should know all that she can about surgery—that the greater her knowledge and the more intelligent her coöperation with the surgeon, the abler she will be to care for and satisfy her patients. So his emphasis is on the academic and technical aspects of surgical nursing. We hope that when his book comes to a second edition, as we are sure it will, he will enrich it with more para-

graphs on bedside nursing like those now included in his discussion of the care of patients following appendectomy, cleft palate repair, and thorocoplasty. In these, he proves that he could contribute as much to the training of nurses as to the educating of them. We wish he would.

TAKE CARE OF YOURSELF. By Jerome W. Ephraim. 287 pages. Illustrated. Simon and Schuster, New York. 1937. Price, $2.00.

Reviewed by MARGARET G. REILLY, R.N., Cambridge, Massachusetts.

THIS BOOK, according to the publisher's note, is a "practical guide to health and beauty." In addition, the jacket declares,

> If you suffer from sore throat, constipation, or sunburn; if you want to check falling hair, stop bleeding gums, or improve your complexion, the author is equipped to analyze your symptoms and prescribe a definite treatment for each; he will also recommend products to buy and what to avoid.

This type of sales promotion recalls the old-time medicine man, whose snake oil was guaranteed to cure all the ills to which mortal man is heir. Fortunately, a very sane and interesting foreword has been written by Dr. Logan Clendening, while the author, with becoming modesty and good taste, has explained in the introduction,

> This book is simply an effort to put into convenient and useful form an accumulated knowledge of chemistry, pharmacology, medicine, and dentistry, so that the users of drugs and cosmetics can profit from the advances made in these fields.

There are eighteen chapters covering such diverse subjects as "The Common Cold," "The Safe Way To Reduce," "Your Morning Shave," "Your Teeth and How To Keep Them Healthy," "The Sure Way To Check Dandruff," "The Truth About Vitamins," and "The Secret of Buying Drugs and Cosmetics."

The author first became interested in studying the most common household remedies and how they are manufactured and advertised. Later his work led him into the fields of medicine and dentistry. For fifteen years he has been accumulating valuable scientific information, which has finally been gathered together into this practical handbook. There are excellent references at the end of each chapter, which add appreciably to the authoritative value of the book.

The first chapter entitled "The Intelligent Buyers' Guide" is well worth reading, for it emphasizes the extreme importance of adopting a critical attitude in buying drugs and cosmetics which, he declares, "means getting pertinent facts and eliminating preconceived notions, unsubstantiated claims, hearsay, pseudo-science, and irrelevant appeals." Such a point of view is not, of course, limited to the realm of intelligent buying, being equally essential as a requisite of intelligent living.

Of the chapter "The Secret of Buying and Using Cosmetics," Dr. Clendening says, "The author debunks some of the fallacious ideas about the value of some types of beauty preparations." If the reader doubts this statement, he need only read a recent report by the American Medical Association of a new cosmetic cream, which was heralded by advertisers as "the most astonishing development in beauty care ever offered to Americans."

The author's style is clear and concise, and his scientific information adaptable to the comprehension and use of lay persons. His attempts at humor are, at times, painfully obvious, and seem quite out of place in a handbook, whose purpose is to give serious and reliable advice.

It is, nevertheless, interesting and worth while as a handbook which may be read with profit by nurses, pupils, or graduates, and which certainly could be recommended as supplementary reading for courses in personal hygiene, dermatology, dentistry, and nutrition.

THE SOCIAL COMPONENT IN MEDICAL CARE. By Janet Thornton, in collaboration with Marjorie Strauss Knauth. 411 pages. Columbia University Press. New York. 1937. Price, $3.00.

Reviewed by DOROTHY CARTER, R.N., General Director, Community Health Association, Boston, Massachusetts.

THERE HAS BEEN INCREASING EMPHASIS in the last few years, particularly in the study and preparation for the new *Curriculum Guide* on the social and health aspects of

nursing. Nurses and nursing educators are finding more that a fresh focus is needed on the patient as a functioning member of society and on those factors that limit his functioning.

The Social Component in Medical Care demonstrates clearly and convincingly that social factors in many instances play an important part in a patient's recovery and return to work. While there is little evidence that adverse social factors actually influence organic disease itself, their significance lies in their effect upon the patient's stability because of the mental strain imposed and the resulting dissatisfaction.

The book is based on a study of 100 unselected cases on the Medical Service of the Presbyterian Hospital in New York City and was carried on through the joint endeavor of a group comprising both physicians connected with the service and medical social workers.

The first part of the book is a series of seventeen "demonstrations" of patients with acute, recurrent, and chronic illness, illustrating the many and varied factors that influence the medical picture. In the remainder of the book the authors analyze and classify in considerable detail, first, the adverse social factors affecting recovery and, second, the remedial measures undertaken. The first she discusses under two main headings, those factors affecting subsistence, including faulty personal habits as well as inadequate income and protection, and those affecting satisfaction involving primarily emotional adjustment.

Remedial measures are discussed again under two main headings, those undertaken to control environment and those designed to influence conduct. Nurses whose job involves a teaching function with patients, especially in the field of public health, will find Miss Thomson's analysis of the processes involved in influencing conduct particularly helpful.

The appendices include abstracts of the 100 cases and an unusually interesting complete case record with a copy of the social worker's day by day notes.

One is impressed, as one always is in reviewing a number of case histories, by the different ways in which patients meet similar situations and by the need for completely individualized treatment.

While the authors feel that more study and exploration are needed to substantiate the findings, after reading the book one cannot but agree with their conclusions that social factors are an inherent component of medical care and that it is the physician's responsibility to integrate such factors with his physical findings.

THE NURSE'S MANUAL. By the Rev. F. E. White and the Rev. Sr. M. Suitbertha, O.S.D. 139 pages. Catholic Book Publishing Company, New York. 1937. Price, $1.00; postpaid, $1.10.

Reviewed by MAY KNOWLES, R.N., Associate Director, New York Hospital School of Nursing, New York City.

THE AUTHORS of this book have been successful in designing a small yet comprehensive volume for the personal use of the nurse and for her guidance in meeting sick-room problems of a religious nature. The general set-up, binding, and printing of *The Nurse's Manual* will appeal to nurses, because it is attractive in appearance, printed in a type easy to read, and is a size which may be carried in the pocket of the uniform. Although small in structure it is very complete in content.

It contains prayers for many occasions, such as morning and evening prayers, prayers for confession and communion, a short method of assisting at Mass, novena prayers to the Sacred Heart and the Blessed Virgin, and special devotions.

The second part of the manual consists of a series of instructions for nurses on how to meet their responsibility to Catholic patients. It describes the duties of the nurse when assisting the priest during the administration of the last sacraments, what she should do in emergency baptism, and prayers suitable for the sick and dying. It also includes the authorized prayers from the "Roman Ritual for the Dying and the Faithful Departed."

This small book is a real contribution to the field of nursing literature. It contains in compact form valuable material for the spiritual guidance of the Roman Catholic

nurse, and is a handy reference for other nurses caring for the Roman Catholic patient.

TECHNIQUE OF UNDERWATER GYMNASTICS. By Charles Leroy Lowman, M.D. 276 pages. Illustrated. American Publications Company, Los Angeles. 1937. Price, $5.00.

Reviewed by JESSIE L. STEVENSON, R.N., Supervisor, Orthopedic Division, Visiting Nurse Association of Chicago and Instructor in Physical Therapy, Northwestern University Medical School, Chicago, Illinois.

THIS BOOK is presented to assist those concerned with the practical application of corrective and therapeutic exercises in water.

Part I, "History and Use of Physiotherapeutic Pools," contains many practical suggestions on the construction and physical equipment of pools. Other sections of the book discuss the general theory of the use of underwater gymnastics, the conditions suitable for hydro-gymnastic treatment, and the field of application for corrective aquatics.

This text, with its excellent illustrations, will be welcomed and studied carefully by physicians and physical therapy technicians with similar problems. We believe that it is a valuable reference book for nursing libraries. The alert nurse will wish to be informed on the general principles underlying this form of therapy which has attained such widespread use in hospitals and schools within the last twelve years.

The emphasis upon physiological rest and the practical suggestions for maintaining it at all times cannot fail to impress the nurse with the need for applying and teaching these same principles in the nursing care of the patient. Chapter X, "Deformity Prevention and Correction," is especially valuable.

Many cases of drop feet might be prevented if the advice given on page 119 were followed: "In all prolonged illnesses necessitating confinement to bed the feet should be supported at right angles to the leg."

The paragraph, "Progress notes" on page 57, contains a classic comment on charting. "Write progress notes as you would write a telegram. Say the most possible in the fewest words."

Answers to "Ask Me Another" Questions

For the questions, turn to pages 61–62.

1. Private Duty Section; Federal Government Section. (Official Directory, any *Journal*)
2. Every other year at the biennial convention of the American Nurses Association. (August, p. 917)
3. Brandine Wiedenbach. (Official Directory, any *Journal*)
4. Clarbel A. Wheeler. (Official Directory, any *Journal*)
5. *The American Journal of Nursing*. (December, p. 1369)
6. Between 7,000 and 8,000. (September, p. 997)
7. Yes, in the Open Forum. (Every *Journal*)
8. Amelia Grant. (Official Directory, any *Journal*)
9. Red Cross membership, $1.00 or more; there are no dues to the Red Cross Nursing Service. (November, p. 1197)
10. The Army Nurse Corps; Navy Nurse Corps; U. S. Public Health Service; U. S. Veterans Administration; and U. S. Indian Service. (November, p. 1239)
11. Four. (Contents page, any *Journal*)
12. Dorothy Deming. (Official Directory, any *Journal*)
13. The nurses associations of Australia, Switzerland, and Roumania. (September, p. 1004)
14. Nellie X. Hawkinson. (Official Directory, any *Journal*)
15. No, although she must be a graduate registered nurse in some state. Some state associations, however, do not provide for non-resident membership. (August, p. 911)
16. Back advertising pages, any *Journal*.
17. The Harmon Plan. (January, p. 21)
18. Official Directory, any *Journal*.
19. Forty to eighty-five cents per month. (February, p. 145)
20. *The American Nurses Association and You; An Outline of Suggestions for Committees on Program of Alumnae Associa-*

sions; Condensed Report of the Special Study of Registry Activity. (June, p. 588; July, p. 804; May, p. 506)
21. Increased. (July, p. 730–31)
22. Kansas City, Mo., April 24–29, 1938. (October, p. 1168)
23. The ANA does not at this time recommend nurse membership in unions. (July, p. 766)
24. The American Nurses Association; the National League of Nursing Education; the American Hospital Association. (June, p. 641)
25. Effie J. Taylor, Yale School of Nursing. (September, p. 1001)
26. Mary E. G. Bliss; Massachusetts; private duty. (October, p. 1169)
27. News About Nursing, in every *Journal*.
28. Eight-hour day; forty-eight hour week. (June, p. 587)
29. The American Nurses Association (statement on front cover of every issue, "published by, et cetera")
30. No. (February, p. 145)
31. What Registries Are Doing, in every *Journal*.
32. To protect the public by ensuring good nursing care. (December, p. 1371)
33. Mrs. Alma H. Scott. (Official Directory, any *Journal*)
34. Chicago University. (August, p. 921)
35. Lists of free and inexpensive materials, in any *Journal* since May 1937.
36. *Public Health Nursing.* (December, p. 1369)
37. Susan C. Francis; Official Directory, back advertising pages, any *Journal*.
38. In 1917. (June, p. 628)
39. Midwest Division; New England Division; Southern Division. (Official Directory, any *Journal*)
40. Illinois (May, p. 558)
41. *Nursing and the Registered Nurse.* (October, p. 1120)
42. More. (July, p. 730–31)
43. 50 West 50th Street, New York City; Official Directory, any *Journal*.
44. Professional books in Books on Professional Subjects; books on travel, poetry, fiction, et cetera, in the Book Parade. (Every *Journal*)
45. *The Study of Nursing Service in Fifty Selected Hospitals*, part of the *Hospital Survey for New York*; made by the Department of Studies, National League of Nursing Education. (May, p. 508)
46. Anna L. Tittman, R.N. (December, p. 1404)
47. Mary M. Roberts, R.N. (Contents page, any *Journal*)
48. The American Nurses Association; forty years, plus (June, p. 586–88)
49. *Illustrative Materials for Use in Nursing Schools; Basic Booklist; A Curriculum Guide for Schools of Nursing.* (March, p. 319; June, p. 610; September, p. 1058)
50. Ida F. Butler (July, p. 802)

CLINICAL

51. Three and one-half to four quarts. (November, p. 1213)
52. To give physiological and local rest to the pulmonary tissues. (April, p. 373)
53. Vitamin A; milk, cream, eggs, codliver oil, carrots, green vegetables. (January, p. 44, 45)
54. Increases depth of respiration. (March, p. 276)
55. Protamine insulin is absorbed very slowly and liberates active insulin in small quantities over a longer period of time, thus preventing wide variations in the blood sugar level. (March, p. 257)
56. Depressing. (March, p. 225)
57. All age groups, from childhood to old age. (February, p. 138)
58. No. You may have acute appendicitis. A cathartic would increase peristalsis, thus increasing the absorption of toxins and the dissemination of toxins and bacteria throughout the peritoneal cavity. In all probability, heat increases absorption. (January, p. 10)
59. Insulin shock treatment (the use of the metrasol convulsive treatment has not yet been widely reported in this country. (May, p. 494)
60. The plugging of a blood vessel by a foreign body. (May, p. 503)
61. Lowers it. (October, p. 1092)
62. It reduces his carbohydrate tolerance. (September, p. 1044)
63. Milk made more easily digestible by subjecting it to high pressure which breaks up fat globules. (September, p. 972)
64. Insulin. (October, p. 1082)
65. When it has a body weight of less than 2,500 grams or five and one-half pounds. (May, p. 457)
66. Eighty to 100 milligrams per 100 cubic centimeters of blood. (February, p. 119)
67. During the first eight to ten weeks of fetal life. (April, p. 339)
68. It passes down the neck and enters the chest cavity, some of its branches going to the pericardium, the others to the diaphragm; it is the motor nerve of the diaphragm (April, p. 376; p. 375)
69. No, it is impaired. (February, p. 120)

Official

International Council of Nurses.—Ex. sec., Anna Schwarzenberg, [illegible] ... 50 W. [illegible] ... Children's [illegible] ... Tower, [illegible] St., [illegible] ... Alma H. [illegible] ... New York City. [illegible] Government [illegible] ... Administration, [illegible] ... Chairman, [illegible] ... Pa. [illegible] ... the National [illegible] ... Organization for Public Health Nursing, [illegible] ... 50 W. 50th St., New York City. [illegible] ... Chairman, A. [illegible] ... Texas.

[illegible] ... Second St., [illegible] ... Memorial [illegible] ... Service, Ex. dir., [illegible] ...

[illegible]—Pres., [illegible] Jones, Truesdale Hosp., Fall River, Mass. Sec., Louise H. Thompson, [illegible] N. H.

Southern Division.—Pres., [illegible] Lewis, George Peabody College for Teachers, Nashville, Tenn. Sec., Olga M. Brelhan, [illegible] Univ. [illegible] Texas.

The American Journal of Nursing Company.—Offices, 50 W. 50th St., New York City. Pres., [illegible] Goostray, Children's [illegible] ... Sec., [illegible] C. [illegible] ... Claremont Ave., New York City. Treas., [illegible] ... York Ave., New York City. [illegible] ... Seattle. Helen McDermott, [illegible] ... L. [illegible] Ontario, Calif. [illegible] ...

The National League of Nursing Education.—Headquarters, 50 W. 50th St., New York City. Pres., Nellie X. Hawkinson, Department of Nursing Education, University of Chicago, Chicago, [illegible] ... Goostray, Children's Hosp., [illegible] ... Ave., Forest Hills, N. Y. [illegible] Claribel A. Wheeler, 50 W. 50th St., New York. Department of Studies, Director, Blanche Pfefferkorn, 50 W. 50th St., New York City.

The National Organization for Public Health Nursing.—Pres., [illegible] Grant, 135 Worth St., New York. General Director, Dorothy Deming, 50 W. 50th St., New York. Joint Vocational Service, Sec., Mary Louise Foster, 130 E. 22nd St., New York.

The Isabel Hampton Robb Memorial Fund and The McIsaac Loan Fund.—Chairman, Alta E. Dines, The A.I.C.P., 105 East 22nd St., New York City. [illegible] ... Mary C. Eden, [illegible] ... Philadelphia, Pa.

American Red Cross Nursing Service.—National Director, Ida F. Butler, American Red Cross, Washington, D. C. Public Health Nursing and [illegible] Service, National Director [illegible] ... American Red Cross, Washington, D. C. Director, [illegible] Area, Lona L. Trott, 1709 Washington Ave., St. Louis. Director, Pacific Branch Area, Gladys L. Badger, Civic Auditorium, San Francisco, California.

Army Nurse Corps.—Superintendent, Major Julia O. Flikke, 1836 Munitions Bldg., Washington, D. C.

Navy Nurse Corps.—Superintendent, Myn M. Hoffman, 1314 Navy Dept., Washington, D. C.

For appointment to the following three federal services, nurses must apply through the Civil Service Commission, Washington, D. C.

United States Public Health Service, Nursing Service.—Superintendent, [illegible] ... Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Veterans Administration, Nursing Service.—Superintendent, Mrs. Mary A. Hickey, Veterans Administration, Washington, D. C.

Indian Affairs, Nursing Service.—Director of Nursing, Elinor D. Gregg, Office of Medical Director, Bureau of Indian Affairs, Dept. of Interior, Washington, D. C.

Association of Collegiate Schools of Nursing.—Pres., Isabel M. Stewart, Teachers College, Columbia University, New York City. Sec., Agnes Gelinas, Skidmore College, Saratoga Springs, N. Y.

State Nurses Associations

Alabama.—Pres., Mrs. J. T. [illegible], [illegible] Hosp., Anniston. Ex. sec., Anne [illegible], [illegible] N. [illegible] St., Birmingham. [illegible] Section, Chairman, [illegible], Baptist Hosp., Birmingham. [illegible] McDonald, 2101 Highland Ave., Birmingham. [illegible], Chairman, [illegible] ... 320 [illegible] ... Chairman, Mrs. [illegible] State Dept. of Health, Montgomery. Sec., [illegible] C. [illegible] Co. Health Dept., Decatur. [illegible] ... Hosp., Birmingham. Sec., [illegible] ... 1[illegible] N. [illegible] St., Birmingham.

Directory

Official Directory

N. E., Atlanta. Private Duty Section, Chairman, Marie Silvers, 1916 Kentucky Ave., Atlanta. Sec., Mae White, 123 Hill St., Thomasville. State League, Pres., Miss Brandon, Grady Hosp., Atlanta. Sec., [illegible], Grady Hosp., Atlanta. Treas., Mrs. Mae Jones, Milledgeville State Hosp., Milledgeville. Examining Board, Pres., Mattie Lee [illegible], 701 Forsyth St., Macon. Joint sec., State Examining Boards, Hon. R. C. Coleman, The Capitol, Atlanta. Ed. supervisor, Lillian Zeller, 111 The Capitol, Atlanta.

Idaho.—Pres., Mrs. Minnie S. Rasmussen, Rupert Gen. Hosp., Rupert. Sec., Mrs. Victoria Youngren, 302 Eighth St., Idaho Falls. Bureau of Occupational License, Department of Law Enforcement, Donald L. Cruickshank, Director, State House, Boise. Examining Board, Pres., Sister Alphonsus, Mercy Hosp., Nampa. Sec., Helen Smith, St. Luke's Hosp., Boise.

Illinois.—Pres., Lenore Tobias, 1819 W. Polk St., Chicago. Ex. sec., Madeleine McConnell, 8 S. Michigan Ave., Chicago. Private Duty Section, Chairman, Mrs. Bertha Goodman, 4447 Greenwood Ave., Chicago. Sec., Gertrude [illegible], 448 Barry Ave., Chicago. Public Health Nursing Section, Chairman, Dorthea Thompson, 1512 Cornelia Ave., Chicago. Sec., L. Mamie Ryman, Jr. High School Bldg., Freeport. State League, Pres., Dorothy Rogers, Nursing Education, University of Chicago, Chicago. Sec., Minnie E. Howe, Children's Mem. Hosp., Chicago. Treas., Mary I. Bogardus, 950 E. 59th St., Chicago. Supt. of Registration, Homer J. Byrd, State Capitol, Springfield.

Indiana.—Pres., Marie Winkler, 808 Majestic Bldg., Indianapolis. Ex. sec., Helen Teal, 717 Circle Tower, Indianapolis. Private Duty Section, Chairman, Grace Witwer, 1244 N. Illinois St., Indianapolis. Sec., Mrs. Mattie Walters, 804½ S. 7th St., Terre Haute. Public Health Nursing Section, Chairman, Marion [illegible], 309 Central Bldg., Ft. Wayne. Sec., Bernice Cole, 808 Majestic Bldg., Indianapolis. State League, Pres., Cordelia Hoeflin, Indiana University Hosps., Indianapolis. Sec., Fern Coy, Indiana University Hosps., Indianapolis. Treas., Grace Marie Howard, Ball Memorial Hosp., Muncie. Examining Board, Pres., Pauline G. Bischoff, Lutheran Hosp., Fort Wayne. Sec., Cordelia Hoeflin, Room 301 State House, Indianapolis. Ed. dir., Mary T. Walsh, Room 301, State House, Indianapolis.

Iowa.—Pres., Mrs. Nellie C. Holmes, 2034 Carey Ave., Davenport. Sec., Mrs. Margaret Stoddard Parker, 307–7th Ave., N. W., Independence. Private Duty Section, Chairman, Mrs. Mattie Lyons, Waverly. Sec., Wilma Willbrock, 1410 5th Ave., S. E., Cedar Rapids. Public Health Nursing Section, Chairman, Margaret Van Acheren, State Health Dept., Des Moines. Sec., Bess Cunningham, Oskaloosa. State League, Pres., Florence Wemlund, 1117 Pleasant St., Des Moines. Sec., Lillian Lindgren, Iowa Lutheran Hosp., Des Moines. Treas., Florence Merrill, University Hosp., Iowa City. Examining Board, Chairman, Vera M. Sage, Burlington Hosp., Burlington. Ex. sec., Wavie Stiles, Room 17, State House, Des Moines. Ed. dir., Viana McCown, Room 17, State House, Des Moines.

Kansas.—Pres., Irma Law, Wesley Hosp., Wichita. Sec., Mrs. Anne Lee Wick, 139 N. Clifton Ave., Wichita. Private Duty Section, Chairman, Clarice Tuttle, 3910 East Elm, Wichita. Sec., Cecelia Peters, 700 South Pershing, Wichita. Public Health Nursing Section, Chairman, Marian Nicholson, 721 Nebraska St., Kansas City. Sec., Mrs. Oma Hunter, 111 Southwest Blvd., Kansas City. State League, Pres., Ethel Templin, Asbury M. E. Hosp., Salina. Sec., Alicia Sayre, Bethany Hosp., Kansas City. Treas., Minnie Cox, McPherson County Hosp., McPherson. Examining Board, Pres., Ethel L. Hastings, Bethany Hosp., Kansas City. Sec., Cora A. Miller, 1224 N. Market St., Emporia.

Kentucky.—Pres., Carrie Woods, Norton Memorial Infirmary, Louisville. Ex. sec., Mrs. Myrtle C. Applegate, 604 S. 3rd St., Louisville. Private Duty Section, Chairman, Ophelia Moore, 270 S. Limestone St., Lexington. Sec., Helen Troy, 134 Fourth Ave., Dayton. State League, Pres., Ruth Merrifield, Deaconess Hosp., Louisville. Sec., Mary T. Gohen, Jewish Hosp., Louisville. Examining Board, Pres., Mrs. Emma Hunt Knoebel, 604 S. 3rd St., Louisville. Sec., Honor Murphy, 604 S. 3rd St., Louisville.

Louisiana.—Pres., Edith Paris, 106 Breard St., Monroe. Sec., Jane E. Martin, 4016 Davidson Court, New Orleans. State League, Pres., Marion Zilley, Touro Infirmary, New Orleans. Sec.-treas., Elizabeth Rowe, Touro Infirmary, New Orleans. Examining Board, Pres., John Snellings, M.D., 320 N. Third St., Monroe. Sec., Julie C. Tebo, 309 Pere Marquette Bldg., New Orleans.

Maine.—Pres., Alice Moore, Eastern Maine General Hosp., Bangor. Sec., Madeline A. Young, Eastern Maine General Hosp., Bangor. Private Duty Section, Chairman, Cecilia Brown, 44 Spruce St., Portland. Sec., Mary Shillo, 94 Best St., Portland. Public Health Nursing Section, Chairman, Mrs. Marion F. Cohen, 6½ Middle St., Augusta. Sec., Juliette A. Gigneire, 151 Pine St., Lewiston. State League, Pres., Alice M. Moore, Eastern Maine General Hosp., Bangor. Sec., Madeline A. Young, Eastern Maine Gen. Hosp., Bangor. Examining Board, Pres., Agnes Nelson, 187 Middle St., Portland. Sec., Mrs. Theresa E. Anderson, Box 493, Pittsfield.

Maryland.—Pres., Maud M. Gardner, 5400 Windsor Mill

Official Directory

[illegible], Baltimore. Ex. sec., Mrs. Blanche G. Powell, 1217 [illegible] St., Baltimore. Private Duty Section, Chairman, [illegible], 3707 York Rd., Baltimore. State League, Pres., [illegible] Savage, Sinai Hosp., Baltimore. Sec., Marion E. [illegible] Johns Hopkins Hosp., Baltimore. Examining Board, [illegible] C. Bartlett, 604 Reservoir St., Baltimore. Sec., [illegible] Helen Ryan, 1217 Cathedral St., Baltimore.

[illegible].—Pres., Blanche A. Blackman, Springfield [illegible]. Ex. sec., and state headquarters, Helene G. Lee, [illegible] Boylston St., Boston. Private Duty Section, Chairman, [illegible] B. Redmond, 40 Palmer St., Arlington. Sec., [illegible] O'Brien, 21 Sheafe St., Brookline. State League, Pres., [illegible] Dieter, Massachusetts Memorial Hosp., Boston. [illegible] L. Campbell, Peter Bent Brigham Hosp., Boston. [illegible] Jacqueline Davis, Faulkner Hosp., Jamaica Plain. [illegible] Board, Pres., William A. Bryan, M.D., Worcester [illegible], Worcester. Sec., Stephen Rushmore, M.D., [illegible], Boston. Supervisor schs. of nursing, Elizabeth E. [illegible], State House, Boston.

[illegible].—Pres., Marian Durell, University Hosp., Ann Arbor. Gen. sec., Olive Sewell, Capitol Savings & Loan Bldg., Lansing. Private Duty Section, Chairman, Mrs. Fern I. [illegible], 16[illegible]1 Sorrento, Detroit. Sec., Norine O'Neill, 501 [illegible], S. E., Grand Rapids. Public Health Nursing Section, Chairman, Louise Knapp, Wayne University, Detroit. Sec., [illegible] Tappan, Kellogg Foundation, Battle Creek. State League, Pres., Lucy Germain, Harper Hosp., Detroit. Sec., [illegible] C. Campbell, Saginaw Gen. Hosp., Saginaw. Treas., [illegible] Lee, Hurley Hosp., Flint. Examining Board, Pres., C. C. [illegible], M.D., Lansing. Sec., Mrs. Ellen L. Stahlnecker, [illegible] Hollister Bldg., Lansing.

Minnesota.—Pres., Esther Andreasen, 409 City Hall, Duluth. Gen. sec., Caroline Rankiellour, 2642 University Ave., St. Paul. Private Duty Section, Chairman, May Leeds, 729 Dayton Ave., St. Paul. Sec., Dorothy Swanson, 1282 Hubbard St., St. Paul. State League, Pres., Daisy Dean Urch, College of St. Teresa, Winona. Sec., Henrietta Davis, Abbott Hosp., Minneapolis. Treas., [illegible] Tofte, Ancker Hosp., St. Paul. Examining Board, Pres., Mrs. Sophia Olson Hein, Children's Hosp., St. Paul. Sec., Leila [illegible], 619 State Office Bldg., St. Paul. Ed. dir., Muriel L. Thomas, 619 State Office Building, St. Paul.

Mississippi.—Pres., Mary E. Dorsey, King's Daughters Hosp., Greenville. Sec., Della Parker, Sanatorium. Private Duty Section, Chairman, Kate Lou Lord, Hattiesburg. Sec., [illegible], Vicksburg. Public Health Nursing Section, Chairman, Mary D. Osborne, State Board of Health, Jackson. Examining Board, Pres., Felix J. Underwood, M.D., State Board of Health, Jackson. Sec., Mrs. Alice W. Finley, Box [illegible], Tupelo.

Missouri.—Pres., Clara Louise Wright, 5535 Delmar Blvd., St. Louis. Ex. sec., Mary E. Stebbins, 1101 Waldheim Bldg., 6 E. 11th St., Kansas City. Private Duty Section, Chairman, [illegible], [illegible] N. 8th St., St. Joseph. Sec., Elise Johnson, 31[illegible] [illegible] Blvd., Kansas City. Public Health Nursing Section, Chairman, Phyllis Dacey, Rialto Bldg., Kansas City. Sec., Dorothy [illegible], 4404 Laclede, St. Louis. State League, Pres., [illegible] E. Peterson, 306 S. Kingshighway, St. Louis. Sec., [illegible], Lutheran Hosp., St. Louis. Treas., Lucille Spalding, 416 South Kingshighway, St. Louis. Examining Board, Pres., L. Eleanor Keely, Boone Co. Hosp., Columbia. Sec., [illegible] Layher, Rooms 615–616 Central Trust Bldg., Jefferson City.

Montana.—Pres., Mrs. Florence Swanstrom, Fonk Apt., Great Falls. Ex. sec., Edith L. Brown, Box 928, Helena. Nursing Education Section, Chairman, Sister John Marie, St. Vincent's Hosp., Billings. Private Duty Section, Chairman, [illegible] Marta, 918 N. Benton, Helena. Sec., Mrs. Glenna [illegible], 1312 Wilder Ave., Helena. Public Health Nursing Section, Chairman, Leslie Stickney, 719 S. Atlantic, Dillon. Examining Board, Pres., Anna Pearl Sherrick, Deaconess Hosp., Great Falls. Sec., Edith L. Brown, Box 928, Helena.

Nebraska.—Pres., Leota Holdrege, 301 City Hall, Omaha. Ex. sec., Mrs. D. A. Foote, 626 Electric Bldg., Omaha. Private Duty Section, Chairman, Teresa Tully, 3625 Dewey Ave., Omaha. Sec., Lianna Koop, 4523 Jones St., Omaha. Public Health Nursing Section, Chairman, Juvia Adams, 344 S. 26th St., Lincoln. Sec., Kate Lincoln, 660 N. 34th St., Lincoln. State League, Pres., Dorothea Mortensen, Bryan Memorial Hosp., Lincoln. Sec., Sylvia Reese, Bryan Memorial Hosp., Lincoln. Treas., Eleanore Carlson, Covenant Hosp., Omaha. Bureau of Examination and Registration for Nurses, Chairman, Arta Lock, Mary Lanning Mem. Hosp., Hastings. Sec., Carol L. Martin, Room 1307, State Capitol, Lincoln. State Director of Nursing Education, Carol L. Martin, Room 1307, State Capitol, Lincoln.

Nevada.—Pres., Mrs. Catherine Sutton, 421 Ralston St., Reno. Sec., Mrs. Florence Mayer, 421½ 13th St., Sparks. Examining Board, Pres., Mary E. Evans, 631 West St., Reno. Sec., [illegible], 1134 W. 1st St., Reno.

New Hampshire.—Pres., Ruth B. Whitcomb, 97 N. State St., Concord. Sec., Sylvia Gagner, 21 Fairmont St., Nashua. Private Duty Section, Chairman, Mary Walsh, 22 Hillcrest Ave., Manchester. Public Health Nursing Section, Chairman, Mrs. [illegible] Hudson, Bible Hill, Claremont Sec., Mrs.

Official Directory

[illegible] Sister Mary [illegible] Pratt, [illegible] Hosp., [illegible] O'Donoghue, [illegible] Hills-[illegible]

[illegible] Memorial [illegible] 17 Academy [illegible] Annie L. [illegible] 10 W. [illegible] Grace [illegible] Clara M. [illegible] Jersey City. Ex-[illegible] Medical Center, Jersey City. [illegible] 17 Academy St., [illegible] 17 Academy St., Newark.

[illegible] Santa Fe. [illegible] Albuquerque. [illegible] St. Joseph's [illegible] Joseph-[illegible] Santa Fe. Public Health Nurs-[illegible] Roswell. [illegible] St. Vincent's Sana-[illegible] Santa Fe. Sec., [illegible] Silver Ave., Albuquerque.

New York—[illegible] St., [illegible] 152 Washington Ave., Albany. [illegible] Herbert J. [illegible] 361 [illegible] New York City. Private Duty Section, Chair-[illegible] Brooklyn. Sec., Chas. F. [illegible] New York. Public Health [illegible] State Dept. of Health, Albany. [illegible] Ave., New York City. [illegible] Skidmore [illegible] Helen Gibbard, [illegible] Grass-[illegible] Ethel Bacon, [illegible] New York City. [illegible] M. Haw-[illegible]

North Carolina—[illegible] 325 Montlieu Ave., High Point. [illegible] Campbell Battie, [illegible] Greensboro. Private Duty Section, Chair-[illegible] Charlotte. Sec., Hazel L. [illegible] Public Health Nursing [illegible] Asheville. [illegible] Bessie [illegible] Hammerling, [illegible] Minnie Clary, [illegible] Joseph-[illegible] Charlotte. Sec. and ed. dir., [illegible] Raleigh.

North Dakota—[illegible] St., Fargo. [illegible] Hosp., Bis-[illegible] Catherine Dunnert, [illegible] Valley City. Public Health [illegible] Sec., Flor-[illegible] Lucille Paulson, [illegible] Grand Forks. [illegible] Trinity [illegible] Good Samaritan [illegible] M. Gilbert, Trinity Hosp. [illegible] Clark, General Hosp. [illegible]

Ohio—[illegible] General Hosp., Cincinnati. [illegible] 50 E. [illegible] Chairman, [illegible] Cincinnati. [illegible] Columbus. Private [illegible] St., [illegible] Public [illegible] Public [illegible] Colling-[illegible] Columbus. Sec., H. M. [illegible] Columbus.

Oklahoma—[illegible] University Hos-[illegible] Oklahoma City. [illegible] 1124 [illegible] Chairman, Mrs. [illegible] Dorothy [illegible] Board, [illegible] Oklahoma City.

Oregon—Pres., [illegible] ABC [illegible] Bldg., Port-[illegible] Portland. [illegible] 3006 [illegible] St. Mary's [illegible] 3600 [illegible] Oregon [illegible] Public [illegible] Portland. [illegible] 304 [illegible] Portland.

Pennsylvania—Pres., [illegible] Chester County Hosp., West Chester. [illegible] 400 N. 3rd St., Harrisburg. Private Duty

Official Directory

[illegible], Chairman, Irene Custer, Pittsburgh. Sec., Alice A. Connolly, 3807 Kayser St., Philadelphia. State League, Pres., [illegible] M. Edgar, Allentown State Hosp., Allentown. Sec., [illegible] Fulper, State Hospital, Scranton. Treas., Helen M. [illegible], Allentown State Hosp., Allentown. Examining Board, Chairman, C. Ruth Bower, Bennett Hall, University of Pennsylvania, Philadelphia. Sec., Elizabeth F. Miller, 362 Education Bldg., Harrisburg.

Rhode Island.—Pres., Louise White, 287 Highland Ave., Providence. Ex. sec., Annie M. Earley, 381 Angell St., Providence. Private Duty Section, Chairman, J. Elizabeth Whiteley, [illegible] St., Pawtucket. Sec., Mrs. Florence N. Thereault, 26 [illegible] Ave., Oakland Beach. State League, Pres., Barbara H. [illegible], Memorial Hosp., Pawtucket. Sec., Mildred T. Lee, [illegible] N. Main St., Providence. Treas., Madeline F. Dill, Rhode Island Hosp., Providence. Committee on Nursing Education, Chairman, [illegible] F. Kelly, M.D., 21 High St., Pawtucket. Sec., [illegible] E. Walsh, 136 Whitford Ave., Providence. Division of [illegible], Chief, Robert D. Wholey, Room 366, State Office Bldg., Providence.

South Carolina.—Acting pres., Mrs. Ruth S. McLean, 522 S. [illegible] St., Spartanburg. Ex. sec., Nellie C. Cunningham, 306 Carolina Life Bldg., Columbia. Private Duty Section, Chairman, Mrs. W. O. Copleston, Georgetown. Sec., Bessie [illegible], 6 Trumbo St., Charleston. Examining Board, Pres., [illegible] Ardell, Charleston. Ex. sec., and educational adviser, Nellie C. Cunningham, 306 Carolina Life Bldg., Columbia.

South Dakota.—Pres., Lorena Ward, Aberdeen. Sec., [illegible] Nelson, [illegible] South St., Rapid City. Private Duty Section, Chairman, Edna Carrico, 814 Columbus St., Rapid City. Sec., [illegible], 522 8th Ave., S. E. Aberdeen. Public Health Nursing Section, Chairman, Alice Olson, Madison. Sec., [illegible], Watertown. State League, Mrs. Anna Haugen, [illegible], Sioux Valley Hospital, Sioux Falls. Sec., Mary Ochs, St. Joseph Hospital, Mitchell. Treas., Sister Mary Conception, St. Luke's Hosp., Aberdeen. Examining Board, Pres., Lorena Ward, Aberdeen. Sec., Carrie E. Clift, Rapid City.

Tennessee.—Pres., Aurelia Potts, George Peabody College, Nashville. Gen. sec. and headquarters, Nina E. Wootton, 414 Cotton States Bldg., Nashville. Private Duty Section, Chairman, Attaway Lancaster, 1823 Highland Ave., Knoxville. Sec., Mrs. [illegible] Morris, 1813-B, Hayes St., Nashville. Public Health Nursing Section, Chairman, Bertha Knipfer, Peabody Dormitory, Peabody College, Nashville. Sec., Mrs. Margaret Johnson, [illegible], Knoxville. State League, Pres., Hazel Lee [illegible], Riverside Fort Sanders Hosp., Knoxville. Sec., [illegible], St. Thomas Hosp., Nashville. Examining Board, Chief Examiner, Erna Holtzhausen, Vanderbilt Hosp., Nashville. Sec., Nina E. Wootton, 414 Cotton States Bldg., Nashville.

Texas.—Pres., Olga M. Brelhan, Baylor Univ. Hosp., Dallas. Gen. sec., A. Louise Dietrich, 1001 E. Nevada St., El Paso. Private Duty Section, Chairman, Mrs. Garth Smiley, 1405 [illegible] St., Fort Worth. Sec., Margaret Nolan, 3321 Douglas St., Dallas. State League, Pres., Ola McClusky, Bradford Mem. Hosp., Dallas. Sec.-treas., Mrs. Zora McAnelly Fiedler, Baylor Univ. Hosp., Dallas. Examining Board, Pres., Mrs. Katherine D. [illegible], 3921 Potomac St., Dallas. Sec., Mrs. Eloween [illegible], [illegible] Milam Bldg., San Antonio. Ed. sec., Julia C. [illegible], [illegible] Milam Bldg., San Antonio.

Utah.—Pres., [illegible] Johnson, Latter Day Saints Hosp., Salt Lake City. Sec., Louella Mahaney, Salt Lake Gen. Hosp., Salt Lake City. Private Duty Section, Chairman, Dorothy [illegible], 475-5th Ave., Salt Lake City. Sec., Rosannah Winter, [illegible] N. Main St., Salt Lake City. State League, Pres., Sister M. Ann Patricia, Holy Cross Hosp., Salt Lake City. Sec.-treas., Rhoda Clark, Latter Day Saints Hosp., Salt Lake City. Department of Registration, Capitol Bldg., Salt Lake City.

Vermont.—Pres., Mrs. Abbie L. Starkey, 3 Nelson St., Montpelier. Sec., Mrs. Harriet Ashland, Plainfield. Private Duty Section, Chairman, Mary Harty, 35 Spruce St., Burlington. Public Health Nursing Section, Chairman, Clara Pierter, 6 [illegible] St., Waterbury. Examining Board, Pres., Dr. Emilie M. [illegible], Rutland. Sec., Helen C. Churchill, 28 E. State St., Montpelier.

Virginia.—Pres., Geraldine Mew, St. Vincent Hosp., Norfolk. Ex. sec., Mrs. [illegible] Wood Park, [illegible] E. Broad St., Richmond. Educational Section, Chairman, Ruth N. Henley, Med. College of Virginia, Richmond. Sec., [illegible] Showalter, Norfolk Gen. Hosp., Norfolk. Private Duty Section, Chairman, Sallie Ware, 818 [illegible] St., Lynchburg. Sec., [illegible] Acey, 1006 W. Grace St., Richmond. Public Health Nursing Section, Chairman, [illegible], 1700 [illegible] Ave., Richmond. Sec., [illegible], Jackson Memorial Hosp., Lexington. Examining Board, Sec.-treas. and inspector of schools, Josephine McLeod, Grace American Bank Bldg., 4th and Grace Sts., Richmond.

Washington.—Pres., [illegible] Mason, [illegible] W. 25th Street, Spokane. Ex. sec., Cora E. Gillespie, 327 Cobb Bldg., Seattle. Private Duty Section, Chairman, Georgia Finn, Route 1, Box 152, Walla Walla. Sec., Clara [illegible], W. 907 Fifth Ave., Spokane. State League, Pres., Harriet H. Smith, Harborview Hall, Seattle. Sec., Clela Harvey, Tacoma General Hosp.,

Official Directory

Tacoma. Treas., Virginia [illegible], Harborview Hall, Seattle. Committee [illegible], Chairman, [illegible], Olympia. Sec., David [illegible], Dept. of Licenses, Olympia. Ed. dir., Anne [illegible], Dept. of Licenses, Olympia.

West Virginia—Pres., [illegible], Davis Memorial Hosp., Elkins. Ex. sec., May M. Mahoney(?), 55 Capital City Bank Bldg., Charleston. Educational Section, Chairman, Francis [illegible], Ohio Valley Gen. Hosp., Wheeling. Sec., Sister M. Zita, St. Joseph's Hosp., Parkersburg. Private Duty Section, Chairman, Mrs. [illegible], 217 Walnut Ave., Fairmont. Sec., Alice [illegible], 442 Main St., Wheeling. Public Health Nursing Section, Chairman, Mrs. Grayce [illegible], 716½ Lee St., Charleston. Sec., Mrs. Mattie B. Clark, 109 Crawford St., Beckley. Examining Board, Pres., E. F. Heiskell, M.D., Morgantown. Sec., Mrs. Andrew Wilson, 1300 Byron St., Wheeling.

Wisconsin—Pres., Grace A. Knight, Methodist Hosp., Madison. Ex. sec., Mrs. C. D. Partridge, 3727 E. Layton Ave., Cudahy. Private Duty Section, Chairman, Lois Knoller, 2736 N. Cramer St., Milwaukee. Sec., C. Jane Buechler, 3932 N. Lake Drive, Milwaukee. Public Health Nursing Section, Chairman, [illegible], 937 Denton St., La Crosse. Sec., Alice Dillon, Court House, Waukesha. State League, Pres., [illegible] Graves, Mt. Sinai Hosp., Milwaukee. Sec., Catherine [illegible], St. Mary's Hosp., Milwaukee. Treas., Lila B. Fletcher, State of Wisconsin Gen. Hosp., Madison. Bureau of Nursing Education, Director, Barbara A. Thompson, State Board of Health, Madison.

Wyoming—Pres., Mrs. Henrietta Schenk, 620 Illinois, Sheridan. Sec., Mrs. Elizabeth L. Craven, 10 Anderson Apts., Sheridan. Private Duty Section, Chairman, Violet Franchville, Natrona Co. Hosp., Casper. Sec., Mrs. Grace Markley, 9 Garden Homes, Cheyenne. Public Health Nursing Section, Chairman, Valerie Rittenhouse, Univ. of Wyoming, Laramie. Sec., Mrs. Hays, Rawlins. Examining Board, Pres., Mrs. George [illegible], Laramie. Sec., Mrs. M. Eleanor Olsen, 3422 Warren Ave., Cheyenne.

Territorial Associations

Hawaii—Pres., Mrs. David Y. Akana, Board of Health, Honolulu. Sec., Mary Williams, Bd. of Health, Honolulu.

Puerto Rico—Pres., Cecilia Fonseca, Allen St., 10, San Juan. Sec., Mrs. Ana L. Munoz, Allen St., 10, San Juan.